Create Care Standards
Your Frontline Nurses Will Embrace

Strategies for reducing unwarranted care variation at scale

Look inside for:

- Ways to prioritize the right care variation based on cost-savings opportunity
- Tactics to design care standards that align with frontline workflows
- Top opportunities to embed standards through comprehensive long-term support
Care variation reduction

LEARN HOW TO

• Scale efforts to reduce care variation organization-wide
• Prioritize the right care variation based on cost-savings opportunity
• Design care standards that align with frontline clinician workflows
• Successfully embed standards through comprehensive, long-term support
Create Care Standards
Your Frontline Nurses Will Embrace

Strategies for reducing unwarranted care variation at scale
Nursing Executive Center

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Advisors to Our Work

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Executive Summary

Care Variation Reduction an Untapped Cost Savings Opportunity

Reducing unwarranted care variation is critical for improving both care quality and financial performance. Faced with ever-shrinking margins, chief financial officers are looking beyond traditional cost levers and identifying care variation reduction as a massive—and much needed—source of potential cost savings. Our internal analysis confirms a significant care variation reduction cost savings opportunity within facilities and across health systems.

Leaders Struggle to Scale Care Variation Reduction Efforts

Many pioneers tackling care variation have identified a common challenge: it is difficult to translate care standards into daily practice. For example, one prominent health system approved 106 care pathways, yet only 14 were fully implemented.

This represents the broader challenge many organizations are wrestling with: how to efficiently scale efforts to reduce care variation across multiple standards and facilities.

Create Care Standards the Front Line Will Embrace

To successfully scale efforts to reduce care variation, leaders should follow the approach shown here. Leaders first need to ensure their organization has adequate performance across the four foundational elements of care variation reduction. Once these elements are in place, leaders can begin spinning the care variation reduction flywheel.

This publication focuses on the three highlighted components of the care variation reduction flywheel: prioritizing, designing, and embedding care standards. Specifically, this report contains tactics that will help leaders implement care standards that will be easier—not harder—for frontline nurses to implement, and yield cost savings.
Introduction

The Cost Imperative to Reduce Care Variation
Today’s health care organizations contend with a host of financial pressures, including reimbursement cuts, shifting payer mix, and rising pharmaceutical costs. These financial pressures are not going away; rather, they represent the new environment in which hospitals and health care organizations must operate moving forward.

The cumulative impact of financial pressures is that most health care organizations are left with a margin problem. The Congressional Budget Office (CBO) projects that between one-third and one-half of hospitals nationally will have negative margins by 2025. These projections suggest that most hospitals will need to significantly reduce costs to remain financially viable in the near term.

Hospitals Projected to Be in the Red by 2025
Even with Moderate Productivity Growth, Margins in Danger

Hospital Financial Performance
CBO’s Projection for 2025, Assuming 0.4% Yearly Productivity Growth

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Aggregate margin</th>
<th>Share of hospitals with negative margin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>6.0%</td>
<td>27%</td>
</tr>
<tr>
<td>Scenario 1</td>
<td>2.6%</td>
<td>47%</td>
</tr>
<tr>
<td>Scenario 2</td>
<td>4.3%</td>
<td>36%</td>
</tr>
<tr>
<td>Scenario 3</td>
<td>3.1%</td>
<td>42%</td>
</tr>
<tr>
<td>Scenario 4</td>
<td>1.6%</td>
<td>51%</td>
</tr>
</tbody>
</table>

Add:
- Rate cuts
- Demographic change
- Coverage expansion
- DSH cuts
- Readmit/HAC penalties
- Continued sequestration
- Documentation and coding adjustments
- MU penalties

The Default Approach

Setting Cost Savings Goals Based on Budget Allocation

Typical Hospital Operating Costs

As shown here, chief financial officers are looking beyond traditional cost savings levers and identifying care variation reduction (CVR) as a massive—and much needed—source of potential cost savings. Accordingly, many organizations have set aggressive CVR cost-savings targets and aim to save tens of millions of dollars—often within only a few years.
To quantify the national cost-savings opportunity for care variation reduction, Advisory Board researchers conducted an analysis using data from 468 hospitals in the the top quartile of performance for mortality rate, complication rate, readmission rate, and length of stay. Additional details of the analysis are shown here.

Methodology for Sizing the National CVR Opportunity
Advisory Board’s Proprietary Analysis

Executive Summary
- Defined high-performing cohort for each service line based on quality outcomes: mortality rate, complication rate, readmission rate, and length of stay.
- Assessed prevalence of variation in care delivery by comparing cost spread for high-performing cohort vs national cohort.
- Quantified savings opportunity by comparing high-performing cohort’s median cost per case against each individual facility’s average cost per case.

Principal Cohort:
- 468 general hospitals
- 20.2M patients
- Minimum of 100 licensed beds
- At least 8 cases in each APRDRG-severity group

Key Strengths:
- Benchmark group determined by quality outcomes rather than cost
- Comparison conducted at the APRDRG-severity level
- All-payer data rather than Medicare-only population

Limitations:
- Costs estimated using hospital-specific cost-to-charge ratios
- Data adjustments cannot account for all clinical, demographic, and operational differences between organizations

The results of this analysis indicate a significant national cost savings opportunity associated with reducing care variation. For small hospitals, defined as facilities with 100-200 beds, the average care variation reduction cost savings opportunity is about $10 million. For large hospitals, defined as facilities with over 400 beds, the potential savings are nearly $80 million.

Sizing the Potential Return on Reducing Care Variation
Average Savings Opportunity\(^2\) from Matching Top-Quartile Performance

<table>
<thead>
<tr>
<th>Hospital Size</th>
<th>All Conditions</th>
<th>Top 30 Conditions</th>
<th>Percentage of Hospital Spending that Could Be Reduced by Addressing the Top 30 Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>All hospitals</td>
<td>$29,308,295</td>
<td>$13,662,173</td>
<td>14.2%</td>
</tr>
<tr>
<td>100-200 beds</td>
<td>$9,706,754</td>
<td>$4,298,737</td>
<td>11.1%</td>
</tr>
<tr>
<td>201-400 beds</td>
<td>$23,103,043</td>
<td>$9,311,578</td>
<td>10.8%</td>
</tr>
<tr>
<td>&gt;400 beds</td>
<td>$79,422,903</td>
<td>$30,478,917</td>
<td>13.6%</td>
</tr>
</tbody>
</table>

1) From the Advisory Board’s Crimson Continuum of Care Database.
2) Assumes complete elimination of variance between typical facility and benchmark cohort. Actual opportunity must be downward adjusted for underlying clinical, demographic, and operational differences between organizations.

Source: Nursing Executive Center interviews and analysis.
As organizations attempt to reduce care variation, the challenge many wrestle with is how to efficiently scale their efforts across multiple standards and facilities. For example, one prominent health system approved 106 care pathways, but only 14 were fully implemented.

The reason many organizations struggle to scale their efforts is that leaders typically cherry-pick isolated opportunities for reducing care variation. There are two problems in doing so. First, efforts often remain siloed. Second, it’s difficult to sustain momentum across too many individual projects. Once clinicians begin to focus on the fourth or fifth opportunity, they struggle to continue making progress on the first.

To successfully scale—and sustain—care variation efforts, leaders need a different strategy.

Leading Providers Struggling to Scale Efforts

Hill Valley Health System’s1 Care Standard Bottleneck

106 Approved care standards
14 Fully implemented care standards

“I have 100 improvement initiatives on my plate. Each initiative takes nine months. I don’t have nine months times 100.”

CEO, Medical Group

1) A pseudonym.

Source: Nursing Executive Center interviews and analysis.
To successfully scale care variation reduction efforts, leaders should follow the approach shown here. This pyramid reflects the learning of pioneers in care variation reduction.

**Foundation**

The base of the pyramid includes the four foundational elements on which to anchor your care variation reduction efforts. While none of these needs to be perfect, you must achieve decent performance on each before you move up the pyramid and begin spinning the CVR flywheel.

Your **clinical analytics** must enable you to do two things: First, they should help you identify where to focus your care variation reduction efforts to improve cost and quality. Second, they should help you measure your compliance and outcomes.

You need a level of **clinician engagement** in which the vast majority of clinicians are supportive of new initiatives and have bought into care variation reduction.

You need **clinical governance** that can drive enterprise-wide clinical standardization focused on cost and quality.

Last but not least, your organization needs effective **supply chain management**. Many early cost savings will come through standardizing supplies.

---

**Achieving High-Reliability Enterprise-Wide**

*Advisory Board Framework for Minimizing Care Variation at Scale*

For additional guidance on foundational elements, see the following resources available at advisory.com/nec

- The System Blueprint for Clinical Standardization
- The National Prescription for Nurse Engagement
Once your foundation is in place, you should start spinning the CVR flywheel.

**Flywheel**

Leaders can start their efforts at any point in the flywheel, but most organizations start with prioritization. The goal of spinning the CVR flywheel is to continually move through the process of prioritizing which care to standardize, designing care standards, embedding them into practice, and measuring compliance and cost and quality outcomes.

The focus of this study is how to get the CVR flywheel spinning.

**Culture**

A high-reliability culture is at the top of the pyramid because it is the result of a comprehensive strategy to reduce care variation—not the starting point. If you start your care variation reduction efforts with culture alone (and without the support of the foundation and flywheel), efforts may feel hollow and disconnected from clinicians’ daily experience.

For additional guidance on high-reliability, see the following resources available at advisory.com/nec

- The High-Reliability Clinical Enterprise
- Instilling Frontline Accountability

Source: Nursing Executive Center interviews and analysis.
Care Variation Reduction Audit

This audit maps directly to the Advisory Board Care Variation Reduction Framework and is designed to help you identify areas of strength—and opportunity—within your organization. We recommend you first tackle improvement opportunities in the foundation section. Once you have addressed those, we recommend addressing opportunities in the flywheel section and then in your culture.

**FOUNDATION**

**Actionable Clinical Analytics**
1. Have clinical leaders approved your processes for risk and severity adjustment and attribution?
2. Do your clinical dashboards trigger responsive action on top improvement opportunities?
3. Can clinicians access near real-time performance data and comparative benchmarks online?

**Frontline Clinician Engagement**
1. Do clinician rewards, financial and non-financial, encourage the delivery of high-reliability care?
2. Are clinician roles on committees and task forces concerning care standards all filled?
3. Do frontline clinicians trumpet the benefits of care standardization in conversations with peers?

**Implementation-Oriented Clinical Governance**
1. Is final authority over care standards held by a system-level committee?
2. Do clinical consensus groups strive to develop care standards that are easy to follow?
3. Are clinical consensus groups staffed with project managers and process design experts?

**Effective Supply Chain Management**
1. Are clinicians aware of price and utilization data for devices and other high-cost supplies?
2. Are physician preference items reviewed for standardization opportunities at least once a year?
3. Do you think your materials management department secures the best possible pricing?

**FLYWHEEL**

**Prioritize**
1. Do potential savings from standardizing targeted care processes sum to system financial goals?
2. Do frontline providers have the bandwidth to absorb and apply the number of standards you plan to roll out?
3. Have you properly valued the return on standardizing routine care in multiple care pathways?

Source: Nursing Executive Center interviews and analysis.
Care Variation Reduction Audit (cont.)

(Re)design
1. Can frontline clinicians accurately explain your process for creating and refining care standards?
2. Do you consider how to revise clinical specifications to minimize changes to existing workflows?
3. Do you quantify and equip leaders to head off the most likely points of practice deviation?

Embed
1. Do you have one template for documenting new care standards and key rollout components?
2. Is your alert adherence rate greater than 20% and improving?
3. Does your clinical decision support intake process actively steer requestors away from intrusive alerts and toward guided care tools?

Measure
1. Do standardized care processes automatically capture data to measure adherence?
2. Can you quantify the savings actually achieved from standardizing a care process?
3. Can you describe three instances in the last year where standardized processes with high adherence rates were revised due to insufficient impact?

CULTURE

High-Reliability Compact
1. Could the clinicians you see today articulate current organizational goals and targets for reducing care variation?
2. Have you heard clinicians question peers who depart from care standards in the last month?
3. Is your commitment to high-reliability care a competitive advantage in recruiting clinicians?

Source: Nursing Executive Center interviews and analysis.
There are two common challenges that surface when organizations complete the Care Variation Reduction Audit.

The first challenge is shown here: overreliance on individual clinicians to drive standardization. Organizations that struggle to embed care standards often cite clinician resistance and limited bandwidth to learn new care standards.

While these are common challenges, they are symptoms of a greater problem: care standards are often designed without clinicians’ workflow in mind. As a result, care standards are difficult for frontline caregivers to use, so they push back or struggle to adhere to them. For this reason, effective care variation reduction requires a mindset shift. Rather than focusing on individual clinician compliance, organizations should focus on designing standards that are feasible—and easy—for all caregivers to follow.

Barrier 1: Overreliance on Individuals

Commonly Cited Reasons for Low Standard Adherence

**Individual Clinicians’ Resistance**

- Clinicians do not agree with the evidence
- Clinicians are hesitant to deviate from their training or experience

**Individual Clinicians’ Limited Bandwidth**

- Clinicians prioritize direct patient care
- Clinicians have limited time available to learn new standards

**Standards Are Too Hard to Follow**

“We put so much effort into creating the standard—we reviewed evidence, sought input, came to consensus—and it still failed. We realized we didn’t fail because we didn’t have a standard; we failed because we didn’t have a functional standard that could actually be adopted.”

System CMO, Large Health System in Northeast

Source: Nursing Executive Center interviews and analysis.
The second challenge that many organizations encounter is insufficient clinical governance.

Effective clinical governance includes two types of groups: clinician-led clinical consensus groups (CCGs) that define new care standards, and an enterprise-wide oversight committee of clinical executives. The oversight committee sets system-wide goals for care variation reduction and has final approval over new care standards from the CCGs.

One example of an organization with an effective clinical governance structure is Banner Health. Banner has a Care Management Council, which includes all facility-level CMOs and CNOs. The Care Management Council oversees 22 clinical consensus groups, each of which is co-led by a physician and nurse leader.

Once organizations have implemented effective clinical governance for care variation reduction, they are ready to standardize care. The remainder of this publication provides tactics to do so effectively, by spinning the CVR flywheel introduced on pages 12 and 13.

Banner Health’s Governance for Reducing Care Variation

Care Management Council Oversees All Clinical Consensus Groups

1. Clinical Consensus Groups (CCGs)
   - Representation:
     - Multidisciplinary clinicians including physicians and frontline nurses
     - Supported by process experts
   - Responsibilities:
     - Identify drivers of variation
     - Review external evidence and internal best practices
     - Come to consensus on new clinical standards

2. Enterprise-Wide Oversight Committee
   - Representation:
     - Clinical executives including CMOs, CNOs
     - Clinical working group leads
   - Responsibilities:
     - Set enterprise-level goals for care variation reduction
     - Approve new standards
     - Prevent duplicative work across the enterprise

Source: Banner Health, Phoenix, AZ; Nursing Executive Center interviews and analysis.
Create Care Standards Frontline Nurses Will Embrace

Strategies for Reducing Unwarranted Care Variation at Scale

1. Focus on Cost Variability First
   1. Cost-Driven DRG Prioritization
   2. Cost-Driven “Horizontal” Prioritization

2. Front-Load Workflow Considerations
   3. Front-Loaded Process Design
   4. Designated Design Team
   5. Enabler Identification
   6. Rollout Readiness Assessment

3. Provide Enterprise-Level Rollout Support
   7. Implementation-Ready Toolkit
   8. Facility Implementation Lead
   9. Enterprise-Wide Change Calendar

4. Activate Frontline Nurses in Care Variation Reduction
   10. Frontline Feedback Loop
   11. Peer Coach Cohort
   12. CVR Primer for Preceptors

Prioritize   Design   Embed

To get the CVR flywheel spinning at your organization, we recommend starting with the first three components: prioritize, design, and embed. The Nursing Executive Center’s four-part framework will help you do so.

First, prioritize care variation based on cost variability. Most organizations focus on quality variability alone. By using cost variability as a primary screen, you will ensure that your organization achieves the savings it needs.

Second, design care standards that are easy for frontline nurses to follow by considering workflow implications of new care standards before rollout.

Third, embed new care standards by providing consistent rollout supports across the enterprise to facilitate initial implementation.

Fourth, activate frontline nurses to reinforce standards in the long term.

Collectively, these four strategies will help nursing teams with the first three components of the CVR flywheel: prioritize, design, and embed. The fourth component, measure, will be covered in a future publication.

Source: Nursing Executive Center interviews and analysis.
Before reviewing the tactics, it's important to clarify the terms used through the remainder of this book. For the purposes of this book, we define a “care standard” as an expected clinical practice as defined and approved by an organization. We define a “care pathway” as a series of related clinical practices expected across a clinical episode for a given condition or procedure. As you can see in the example here, care pathways can be cross-continuum and often include multiple care standards.

### Defining Our Terms

*Care Pathway Is Made Up of Multiple Care Standards*

**Care Pathway:**
A series of related clinical practices expected across a clinical episode for a given condition or procedure

**Care Standard:**
An expected clinical practice as defined and approved by an organization

### Example of Standards Included in Heart Failure Pathway

1. **Care Standard:**
   - Standard BNP\(^1\) order placed during ED\(^2\) triage

2. **Care Standard:**
   - No more than 2 chest X-rays ordered for <5 day stay

3. **Care Standard:**
   - Cardiology follow-up scheduled within 10 days of discharge

---

1) Brain Natriuretic Peptide
2) Emergency department.

Source: Nursing Executive Center interviews and analysis.
Focus on Cost Variability First

- Tactic 1: Cost-Driven DRG Prioritization
- Tactic 2: Cost-Driven “Horizontal” Prioritization
An Incomplete Approach to Prioritizing Care Variation

Commonly Cited Drivers of Organizations’ CVR Priorities

<table>
<thead>
<tr>
<th>Quality Data</th>
<th>Clinician Engagement</th>
<th>External Influences</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Care associated with a recent sentinel event</td>
<td>• Individual clinician interests</td>
<td>• Payer requirements</td>
</tr>
<tr>
<td>• Falling quality indicators</td>
<td>• Service lines or clinical areas with highly engaged clinicians</td>
<td>• Policy changes</td>
</tr>
</tbody>
</table>

The Missing Driver: Costs

• Care with variable costs per case
• Utilization of high-cost resources

Given the intense margin pressures facing hospitals and health systems, cost variability must be a primary driver for prioritizing which care to standardize—yet organizations often prioritize other factors.

The most commonly used criteria are shown here: quality data, clinician engagement, and external influences such as payer requirements. These criteria are important, but leaders who focus on these three criteria alone overlook meaningful cost-savings opportunities.

The most progressive organizations don’t ignore quality data and other key considerations, but they use cost variability as the primary driver when setting their care variation reduction agenda.
When prioritizing which care to standardize, organizations have two opportunities to achieve cost savings.

Start by prioritizing specific clinical pathways or procedures, such as knee joint replacement or treatment of chronic obstructive pulmonary disease. Think of this as “vertical” care, because it often falls within a single service line.

In addition to assessing opportunities to reduce variation for vertical care, you should also consider care processes that impact multiple conditions or procedures, such as Foley catheter removal, medication administration, or ambulation protocols. Think of this as “horizontal” care, because it occurs across multiple service lines.

To maximize cost savings through care variation reduction (CVR), leaders must consider both vertical and horizontal care. The two tactics in this section will look at each opportunity in turn.

---

**Applying a Cost Lens to Standardization**

*Two Types of Care to Standardize*

---

**“Vertical” Care Standardization by DRG**

- Nursing
- Pharmacy
- Imaging
- Laboratory
- Therapy
- Purchasing

**“Horizontal” Care Standardization by Care Process**

- Internal Medicine
- Cardiology
- Women and Newborn
- Critical Care
- General Surgery
- Cardiothoracic Surgery
- Neurosurgery
- Orthopedic Surgery

---

Source: Nursing Executive Center interviews and analysis.
Tactic 1: Cost-Driven DRG Prioritization

**Tactic in Brief**

Use cost-savings opportunity as a primary consideration when deciding which clinical conditions and care pathways to standardize. The goal is to reduce the care variation that will maximize cost savings for the organization.

**Rationale**

When organizations select which conditions or care pathways to standardize, they often use quality data to identify their greatest opportunities for improvement. This approach overlooks the significant cost savings organizations need to achieve. By adding cost-saving opportunity as a primary screen, organizations reduce care variation that will improve quality and reduce costs.

**Implementation Options**

**Option 1: Choose opportunities from the Care Variation Short List**

Select APR-DRGs from the Care Variation Short List, based on Advisory Board’s proprietary analysis of the top cost savings opportunities nationally. This option is best suited for organizations that don’t have the internal capability to do a custom assessment.

**Option 2: Establish balanced prioritization criteria to guide decision-making**

Establish clear prioritization criteria to determine which care variation reduction projects will be supported. That set of criteria should include cost savings as a primary consideration. This option is best suited for organizations that have the capability to do a custom assessment internally.

**Option 3: Set hard cost savings targets for clinicians**

Assign cost savings targets to clinical consensus groups, along with the freedom to meet those targets however they want. This option is best suited for organizations that want more decision-making authority among frontline clinicians.

**Tactic Assessment**

We highly recommend that all organizations account for costs when choosing which DRGs to standardize. Given the significant cost pressures facing health care organizations today, adding a cost filter is crucial to ensure that organizations improve financial performance.

Source: Nursing Executive Center interviews and analysis.
Most Opportunity Assessments Follow the Same Logic

To prioritize which vertical care to standardize, most organizations follow a version of the process shown here.

There are two ways this process can go wrong. First, organizations often prioritize the wrong conditions in steps 1 through 3 if they do not consider cost variability while benchmarking and rank-ordering potential APR-DRGs. Second, Clinical Consensus Groups (CCGs) often spend so much time and effort on the first three steps, that they often rush through steps 4 and 5—where their expertise is especially needed.

To prioritize the right vertical care variation—and use CCGs’ time most effectively—clinical executives should use cost to determine care variation reduction priorities in the C-suite, and then engage CCGs in steps 4 and 5.

Clinical executives have three options to use cost as a primary criterion for prioritizing care to standardize. The following pages provide additional detail on each option.

---

### Five Basic Steps

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Identify Gap to Benchmark</td>
</tr>
<tr>
<td>2</td>
<td>Rank Order Opportunities</td>
</tr>
<tr>
<td>3</td>
<td>Identify Internal Variation</td>
</tr>
<tr>
<td>4</td>
<td>Root Cause the Drivers of Variation</td>
</tr>
</tbody>
</table>

---

1. **All Patients Refined Diagnosis Related Groups**

<table>
<thead>
<tr>
<th>APR-DRG</th>
<th>Patient Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>APR-DRG A</td>
</tr>
<tr>
<td>B</td>
<td>APR-DRG C</td>
</tr>
<tr>
<td>C</td>
<td>APR-DRG F</td>
</tr>
<tr>
<td>D</td>
<td>APR-DRG F</td>
</tr>
<tr>
<td>E</td>
<td>APR-DRG E</td>
</tr>
</tbody>
</table>

---

Wrong conditions prioritized because costs aren’t considered

CCGs don’t get here because they spent too much time on previous steps

---

Source: Nursing Executive Center interviews and analysis.
Option 1: Choose opportunities from the Care Variation Short List

The first option for using cost as a primary prioritization screen is the Care Variation Short List. Organizations that do not have the internal capability to conduct a custom opportunity assessment can prioritize APR-DRGs to standardize based on the results of Advisory Board’s analysis of the national care variation reduction cost savings opportunity. You can find details of the analysis on page 10 of this publication.

The final Care Variation Short List represents the top 20 vertical care opportunities with the greatest potential for cost savings nationally. For most organizations, the APR-DRGs on this list are a good place to begin your standardization efforts.

### The Care Variation Short List

#### Top Twenty APR-DRGs Driving Cost Savings Opportunity

<table>
<thead>
<tr>
<th>APR-DRG</th>
<th>Average Cost Savings Opportunity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Septicemia &amp; disseminated infections</td>
<td>$1,867,776</td>
</tr>
<tr>
<td>2. Percutaneous cardiovascular procedures without acute myocardial infarction</td>
<td>$697,287</td>
</tr>
<tr>
<td>3. Craniotomy except for trauma</td>
<td>$640,793</td>
</tr>
<tr>
<td>4. Heart failure</td>
<td>$610,373</td>
</tr>
<tr>
<td>5. Cesarean delivery</td>
<td>$607,678</td>
</tr>
<tr>
<td>6. Vaginal delivery</td>
<td>$593,524</td>
</tr>
<tr>
<td>7. Major small &amp; large bowel procedures</td>
<td>$591,709</td>
</tr>
<tr>
<td>8. Dorsal &amp; lumbar fusion procedures</td>
<td>$586,645</td>
</tr>
<tr>
<td>9. Normal newborn or neonate with other problem</td>
<td>$559,678</td>
</tr>
<tr>
<td>10. Cerebrovascular accident and precerebral occlusion with infarction</td>
<td>$504,037</td>
</tr>
<tr>
<td>11. Kidney transplant</td>
<td>$449,061</td>
</tr>
<tr>
<td>12. Knee joint replacement</td>
<td>$417,936</td>
</tr>
<tr>
<td>13. Cardiac valve procedures without cardiac catheterization</td>
<td>$395,930</td>
</tr>
<tr>
<td>14. Percutaneous cardiovascular procedures with acute myocardial infarction</td>
<td>$352,526</td>
</tr>
<tr>
<td>15. Respiratory system diagnosis with ventilator support 96+ hours</td>
<td>$332,225</td>
</tr>
<tr>
<td>16. Other vascular procedures</td>
<td>$326,186</td>
</tr>
<tr>
<td>17. Other pneumonia</td>
<td>$316,363</td>
</tr>
<tr>
<td>18. Chronic obstructive pulmonary disease</td>
<td>$311,533</td>
</tr>
<tr>
<td>19. Extracranial vascular procedures</td>
<td>$298,276</td>
</tr>
<tr>
<td>20. Hip joint replacement</td>
<td>$296,188</td>
</tr>
</tbody>
</table>

1) For a single facility, based on Advisory Board’s proprietary analysis of 468 hospitals in the Crimson Continuum of Care Database. For details of this analysis, see page 10.

Source: Nursing Executive Center interviews and analysis.
Option 2: Establish balanced prioritization criteria to guide decision-making

The second option for using cost as a primary screen is to establish balanced prioritization criteria. This option is best suited for organizations that have the internal capability to conduct a custom opportunity assessment.

Clinical executives should include cost as a prioritization criterion and then weigh costs against other criteria, such as quality and feasibility. Some organizations introduce cost criterion by modestly weighing it between 10% and 30% of the overall criteria. Other organizations that have more aggressive cost savings targets weigh cost as high as 50%. Collectively, a set of balanced criteria can help organizations effectively benchmark and rank vertical care opportunities.

Giving Cost Criterion More Weight

Smart Prioritization Criteria

1. Degree of variation
2. Number of patients impacted
3. Ease of execution
4. Total dollars at stake

How Heavily Does Your Organization Weigh Costs?

<table>
<thead>
<tr>
<th>Introductory Cost Focus</th>
<th>Your Organization</th>
<th>Aggressive Cost Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>10%-30%</td>
<td>?</td>
<td>&gt;30%-50%</td>
</tr>
</tbody>
</table>

Source: Nursing Executive Center interviews and analysis.
Option 3: Set hard cost savings targets for clinicians

The third option for using cost as a primary prioritization screen is to give CCGs specific cost savings goals. This option is best suited for organizations that want to involve their CCGs in decisions about which care to standardize.

Carolinas HealthCare System (CHS) used this approach to ensure that their care variation reduction efforts yielded tangible cost savings. CHS developed eight clinician-led teams, shown here. Each team represents a clinical area that CHS deemed to have the greatest variability and savings potential. Each team receives a yearly cost savings target and is responsible for identifying improvement opportunities to meet that target. Overall, CHS hopes to save $40 million by the end of 2018, and has achieved more than half of that goal to date.

Asking Clinicians to Show You the Money

Set Cost Targets, but Give Clinicians Autonomy to Achieve Them

Carolinas Breaks Clinical Optimization Goal into Smaller Targets

Annual Targets

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Savings</td>
<td>$10M</td>
<td>$10M</td>
<td>$10M</td>
</tr>
<tr>
<td>Sustained</td>
<td>$15M</td>
<td>$15M</td>
<td>$15M</td>
</tr>
<tr>
<td>Savings</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2017 Team Targets

- Blood: $501K
- General Surgery: $6.5M
- Spine: $2.5M
- Cardiovascular: $2.1M
- LOS: N/A
- Respiratory: $781K
- Women’s Services: $314K
- Ortho: $1.3M

Case in Brief: Carolinas HealthCare System

- Health system based in Charlotte, North Carolina; has 47 owned, managed, or affiliated hospitals
- After a decade of establishing a system-wide quality infrastructure, system leaders engaged physicians to reduce cost of care through a strategy called “clinical optimization” to reduce care variation at their 18 owned hospitals
- System executives set savings goals by comparing Carolinas’ average cost per case to a cohort of comparable health systems, with the ultimate goal of saving $40 million annually by 2018
- Eight clinical optimization teams—each led by a physician and supported by quality, finance, and analytics—were given explicit cost targets to achieve but the freedom to choose how to achieve those targets
- To date, Carolinas has achieved $26 million more in variable cost savings than their 2013 benchmark, with multiple service lines now requesting their own clinical optimization team

1) Sustained savings are targets captured in the prior year that are maintained in subsequent years.
2) 2017 individual team targets do not equal $15 million because cost savings are expected to trickle down to other service lines and generate additional savings.
3) Length of stay.
4) There is no specific goal assigned to the LOS team since the team’s savings are realized across all the clinical optimization teams.

Source: Carolinas HealthCare System, Charlotte, NC; Nursing Executive Center interviews and analysis.

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Driving significant cost savings is a new ambition for many frontline clinicians. To help them effectively identify cost savings opportunities, CHS classifies savings into two types: cost curve shifting and cost curve narrowing.

Cost-shifting opportunities reduce the average cost per case. For instance, switching to a lower-cost device system-wide reduces the average cost per case and shifts the cost curve.

Cost-narrowing opportunities represent a shift in clinical practice toward a single care standard. This narrows the cost distribution curve as the cost of each case approaches a consistent benchmark.

At CHS, clinical optimization teams can pursue both types of opportunities to hit their cost savings targets. Showing clinicians the options they can pursue to save costs helps them achieve ambitious targets.

### Getting Clinicians to Buy Into Cost

**Carolinas Establishes Shared Language and Goals**

#### Two Primary Methods for Cutting Costs

- **Cost Shifting:** Negotiating lower prices for supplies, reducing average cost per case

- **Cost Narrowing:** Changing clinical practice to reduce care variation, narrowing the cost per case toward a common amount

#### Key Selection Criteria for Initiatives

- **Neutral or Improved Quality**
  - Initiatives that threaten quality are never considered

- **Clinician Engagement**
  - Initiatives with established clinician engagement or support are prioritized

### Clinical Optimization Teams Span Cost Saving Methods

- **Spine**
- **Orthopedics**
- **General Surgery**
- **Cardiovascular**
- **Blood**
- **Women’s Services**

Source: Carolinas HealthCare System, Charlotte, NC; Nursing Executive Center interviews and analysis.
Tactic 2: Cost-Driven “Horizontal” Prioritization

Tactic in Brief

Identify the care processes that are both high cost and frequently used across multiple DRGs, and prioritize those processes for care variation reduction. The goal is to standardize processes that will have an outsized cost savings impact due to the sheer volume of patients they impact.

Rationale

When organizations attempt to reduce care variation, they often focus exclusively on specific conditions or care pathways. While this is a smart place to start, they often overlook another important source of cost savings: “horizontal” care processes that are used across multiple care pathways, such as Foley catheter removal, medication administration, or ambulation protocols. Often, nursing teams are already standardizing this type of care and tracking quality outcomes—but overlooking the opportunity to track associated cost savings.

Implementation Components

Component 1: Calculate the cost savings associated with “horizontal” quality indicators
Calculate cost savings of a “horizontal” care standard by linking the number of prevented infections or sentinel events to internal cost benchmarks for treating those infections or events.

Component 2: Prioritize the most costly and most frequently used “horizontal” care standards
Identify “horizontal” care processes that are most frequently used across conditions and care pathways. Prioritize the care processes that are both the most costly and the most common for care variation reduction.

Tactic Assessment

We highly recommend that all organizations calculate the cost savings associated with “horizontal” care processes. Absent this analysis, organizations may overlook the aggregate impact of variation in more routine care processes. In addition to helping organizations reach ambitious financial targets, this tactic also helps nursing teams demonstrate the full value of their work in a resource-constrained environment.

Source: Nursing Executive Center interviews and analysis.
Component 1: Calculate the cost savings associated with “horizontal” quality indicators

The first component of this tactic is to calculate the cost savings associated with quality indicators that nursing already tracks.

Calculating “horizontal” cost savings can be challenging, because many care processes—such as taking vital signs or providing skin care—aren’t captured in charge data. Despite this lack of data, nurse leaders can estimate cost savings using available quality data. For example, most organizations track the reduction in CAUTIs after implementing Foley removal protocols. By working with the finance department to determine the average cost to treat a CAUTI, leaders can calculate the savings from fewer infections, as shown here.

Calculating cost savings—where possible—is important for nursing for two reasons. First, calculating horizontal savings helps the organization reach ambitious financial targets tied to CVR. Second, it demonstrates the full value and contribution of nursing in a resource-constrained environment.

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Running the Numbers on Nurse-Driven Care

A Feasible Analysis to Capture Cost Savings

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Cost Benchmark</th>
<th>Total Cost Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fewer CAUTIs1 after catheter protocol</td>
<td>≈$1,000 Costs per case</td>
<td>$</td>
</tr>
<tr>
<td>Fewer VAPs2 after weaning protocol</td>
<td>≈$25,000 Costs per case</td>
<td>$</td>
</tr>
<tr>
<td>Shorter LOS after early mobility protocol</td>
<td>≈$500 Costs per day</td>
<td>$</td>
</tr>
</tbody>
</table>

| Quality indicators that most organizations already track for “horizontal” standards |
| Internal cost benchmarks that quality and finance teams may already track |

Linking Quality Metrics and Cost Benchmarks

- Decrease in infection rates → Cost per case benchmark
- Decrease in LOS → Cost per patient day benchmark
- Decrease in severity of condition → Comparative cost per case

---

1) Catheter associated urinary tract infections.
2) Ventilator associated pneumonia.
3) Cost benchmarks are for illustrative purposes only and are not recommended to estimate actual cost savings. These benchmarks are pulled from the academic literature, and actual internal costs can vary greatly at each organization. It is recommended that you use your own cost data to conduct a horizontal assessment.

Component 2: Prioritize the most costly and most frequently used “horizontal” care standards

The second component of this tactic is to prioritize the “horizontal” processes that are most costly and that impact multiple pathways—but have not been standardized system-wide.

For example, standardizing antibiotic stewardship protocols can have an outsized impact on costs because it impacts multiple APR-DRGs, such as CABG, hip joint replacement, sepsis, and pneumonia.

An added benefit of this component is that standardizing the most frequently used care processes eases implementation of the more complex clinical pathways that build upon them.

Prioritize the Standardization of Horizontal Care
Complex Care Pathways Build Upon Routine Processes

Importance of Horizontal Care Processes by Clinical Pathway

<table>
<thead>
<tr>
<th>Horizontal Care Processes</th>
<th>CABG(^1)</th>
<th>Hip Joint Replacement</th>
<th>Septic Shock</th>
<th>Severe Pneumonia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antibiotic Stewardship</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge Planning</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foley Catheter Removal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ventilator Protocol</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DVT Prophylaxis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1) Coronary artery bypass grafting.

Source: Nursing Executive Center interviews and analysis.
Front-Load Workflow Considerations

Tactic 3: Front-Loaded Process Design
Tactic 4: Designated Design Team
Tactic 5: Enabler Identification
Tactic 6: Rollout Readiness Assessment
Standards Work Better in Theory Than in Practice

Clinical Specifications Are Not Always Actionable

If care standards are too difficult to integrate into daily practice, they will likely be abandoned by frontline clinicians. Many organizations focus overwhelmingly on achieving clinical consensus when, in reality, frontline workflow is just as important.

As the examples highlighted here demonstrate, failing to take frontline realities into account early on can undermine even the most thoroughly researched and clinically supported care standards. The four tactics in this section equip organizations to create new care standards that align with frontline workflow—and therefore are easier for clinicians to follow at the bedside.

1) Physical therapy.
2) Total joint arthroplasty.

**Standard Excerpt**

**“PT\(^1\) assist all post-operative primary TJA\(^2\) patients with ambulation on the day of surgery”**

**Frontline Reality**

PT leaves at 4:30 p.m., other clinicians are available but they do not meet the care standard.

**“Patients with pneumonia will receive a daily chest X-ray”**

**Frontline Reality**

There are not enough mobile X-ray machines to meet the needs of patients who are too sick to be transported to radiology.

**“On-call nurses to order pre-approved order sets”**

**Frontline Reality**

Not all State Boards of Nursing allow nurses to initiate the order set; nurses must chase down physician to order.

---

1) Physical therapy.
2) Total joint arthroplasty.

Source: Nursing Executive Center interviews and analysis.
Tactic 3: Front-Loaded Process Design

Tactic in Brief
Dedicate time to understanding and addressing workflow constraints before approving a care standard for rollout. The goal is to design care standards that account for existing clinical workflows and avoid roadblocks to adoption after implementation.

Rationale
Care standards are implementable only when they take workflow into consideration. All too often, care standards are approved before workflow considerations are taken into account, resulting in high levels of clinician frustration and low levels of compliance. Allocating time to workflow redesign before a care standard is approved allows for a feasibility check and needed changes to either the standard or workflow.

Implementation Components

Component 1: Front-load workflow considerations
After reaching clinical consensus, invest time in understanding how existing workflows will be impacted by the new care standard. This process should include identifying impacted groups, magnitude of behavior change, and resource investments required.

Component 2: Invest time in understanding frontline workflow realities
Extend the amount of time spent understanding workflow in order to consider potential barriers to adoption at the front line. If barriers do arise, consider reworking the clinical specifications to match workflow before finalizing the care standard.

Tactic Assessment
We highly recommend that all organizations working on care standard design frontload workflow considerations. Reaching clinical consensus will not be valuable if it doesn't inform daily practice. This may require a shift in organizational approach, but is crucial to ensuring that clinical consensus is brought to fruition.

Source: Nursing Executive Center interviews and analysis.
Workflow Considerations a Critical Part of Design

Component 1: Front-load workflow considerations

The first component of this tactic is to front-load workflow considerations during the care standard design process.

Common practice is to reach consensus, approve a care standard, then map the new standard to current workflow. However, we recommend mapping care standards to workflow before they are finalized. This is important because it allows organizations to run a feasibility check before instituting a new care standard.

If any issues are identified, organizations still have time to refine the clinical specifications or workflow before the care standard is finalized.

Resequencing the Care Standard Design Process

**Common Practice**

1. Define clinical specifications
2. Build CDS
3. Map to current workflow
4. Roll out standard

**Progressive Practice**

1. Define clinical specifications
2. Map to current workflow
3. Build CDS
4. Roll out standard
**Component 2: Invest time in understanding frontline workflow realities**

The second component of this tactic is to invest time in understanding workflow realities.

It is not enough to just move workflow considerations earlier in the care standard creation process. To identify and account for workflow constraints, it is equally important to have a robust design process dedicated to understanding frontline realities.

Although the time dedicated to mapping care standards to workflow varies across organizations, this period generally should be equal to or longer than the time spent defining clinical specifications.

Leaders at Banner Health dedicate ample time to translating clinical specifications into an “implementation-ready” care standard. Note that they spend the same amount of time understanding clinical workflow as they do reaching clinical consensus.

During this time they address several components of workflow redesign, including: building a process map to understand existing and future workflows, conducting a risk assessment to pinpoint barriers to adherence, and collaborating with data analysts to define outcome and process measures that can be reliably collected.

### Banner Health’s Design Process

<table>
<thead>
<tr>
<th>Define</th>
<th>Design (2 months)</th>
<th>Implement</th>
</tr>
</thead>
</table>

- **Workflow Design**: Design team meets weekly or bi-weekly to iterate on the process map
- **Informatics Design**: Informaticist collaborates with EHR vendor to build technology that enables the process map
- **Clinical Consensus Group Sign-Off**: Every affected clinical consensus group reviews overall impact of process and informatics changes to provide feedback and approval
- **Success Measures Definition**: Data analysts define outcome and process measures to monitor new workflow
- **Risk Assessment**: Team evaluates the likelihood and impact of failed process steps and addresses obstacles; revisits the process if necessary
- **Supporting Materials Creation**: Clinical educator helps develop education and communication materials

### Case in Brief: Banner Health

- 29-hospital, not-for-profit system headquartered in Phoenix, Arizona, with facilities in Arizona, Alaska, California, Colorado, Nevada, Nebraska, and Wyoming
- In the early 2000s Banner committed to system-wide clinical standardization as a means to improve quality and reduce unnecessary care utilization
- To support this endeavor, Banner built a Care Management Council and Clinical Consensus Groups (CCGs), creating an infrastructure with representative clinical leadership committed to developing and implementing system-wide standards of care
- The CCGs use a three-step process to develop care standards called Define, Design, Implement
- In the design phase, clinicians and supporting team members take the care standard clinical specifications and develop the associated process maps and technology to reliably deliver the standard of care
- The design phase culminates with the development of an implementation toolkit which drives the implementation of standards at each of the 29 facilities within the system

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1) Electronic health record.  
2) 1-2 outcomes measures and 2-3 process measures.  
Source: Banner Health, Phoenix, AZ. Nursing Executive Center interviews and analysis.
Texas Health Resources (THR) also invests substantial time to understand and account for workflow realities during care standard design. Before finalizing a care standard, THR dedicates time to mapping an integrated workflow detailing how people, processes, and technology will be impacted by the new standard.

As pictured here, THR has a six-step design process that they follow when they create new standards. Steps 3 and 4 involve the exploration of existing workflows to pinpoint barriers and allow for iteration before a care standard is approved.

Integrating Clinical and Workflow Considerations

Texas Health Resources’ Six-Step Design Process

1. Define goals and outcomes
2. Define the clinical specifications
3. Identify the enablers required to deliver care
4. Depict integrated workflow: people, process and technology
5. Finalize functional specifications
6. Select process measures

The design teams create “modules” of care, which include:

Case in Brief: Texas Health Resources

- 29-hospital health system with more than 5,500 affiliated physicians; headquartered in Dallas-Fort Worth, Texas
- In 2015, deployed the Reliable Care Blueprinting™ initiative at all 18 acute-care hospitals to reduce unwarranted variation through care redesign
- Reliable Care Blueprinting™ supports Texas Health’s high reliability journey by standardizing care processes across their large organization; involves a six-component design process and extended rollout period to test standards prior to implementation across the organization

Source: Texas Health Resources, Dallas-Fort Worth, TX; Nursing Executive Center interviews and analysis.

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Tactic 4: Designated Design Team

Tactic in Brief
Assemble an interdisciplinary design team that is equipped with the core skills needed to create an actionable care standard. The goal is to build a team that is clearly responsible for—and equipped to—incorporate workflow considerations into the care standard creation process.

Rationale
Clinical expertise is necessary but not sufficient for creating implementation-ready care standards. Care standards that are developed by clinical experts can often be clinically accurate but difficult to follow in day-to-day practice.

To ensure care standards are both clinically sound and actionable at the front line, the design team must include team members who are skilled in project management, process engineering, data analysis, clinical informatics, and clinical education.

Implementation Components

Component 1: Identify design team members who collectively have the core skills required for workflow redesign
Each design team should include expertise in project management, process engineering, data analysis, clinical informatics, and clinical education. While all five core skills should be represented, there does not need to be one full-time expert assigned for each area.

Component 2: Appoint a dedicated project manager to lead the design team
An effective project manager keeps the design team on track and cultivates the relationships needed to drive care standard creation forward. The project manager does not need to have a formal management certification but should be dedicated full-time to steering the creating of care standards. Often hospital employees interested in project management can be upskilled to fill this role.

Tactic Assessment
We highly recommend this tactic for all organizations, because it is foundational to every other tactic in this book, and should be the starting point for organizations working on care standard design. Identifying staff with core skills and reallocating their time requires an up-front investment; however, organizations without designated design teams risk undermining their efforts to reduce care variation reduction by producing impractical standards. Fortunately, most organizations already have internal capacity across the core skills required for care standard design. Organizations usually don’t need to turn to external hires to build a well-rounded design team.

Source: Nursing Executive Center interviews and analysis.
Clinical expertise is necessary but not sufficient for care standard design. Clinicians often lack the non-clinical skills required to operationalize a care standard, such as project management or data analytics. Further, clinicians have limited time available to participate in workflow redesign.

For these reasons, your organization’s CCGs should not be the primary design teams for new care standards. The ideal design team consists of representative clinicians from the appropriate CCG and a majority of in-house design experts.

Assembling a Team with the Right Skills

*Process Experts Should Be Team’s Foundation*

**Clinical Consensus Group**
- 10-30 clinicians
- Reviews external evidence and internal best practices
- Comes to consensus on new clinical specifications

**Designated Design Team**
- Clinicians and process experts
- Designs standard based on clinical specifications
- Operationalizes new standards
- Provides implementation resources

**In-House Process Experts**
- 3-5 process experts
- Lead quality improvement initiatives
- Manage data and measure performance

Source: Nursing Executive Center interviews and analysis.
Component 1: Identify design team members who collectively have the core skills required for workflow redesign

The first component of this tactic is to identify design team members who collectively have the core skills required for workflow design.

There are five core areas of non-clinical expertise that are required to operationalize care standards. They are: project management, process engineering, data analysis, clinical informatics, and clinical education. To design “implementation-ready” care standards, organizations need design teams with expertise across all five areas.

Comprehensive Design Skill Set Is Critical

Five Essential Areas of Expertise Needed to Design Standards

- **Project Management**
  - Project plan management
  - Logistics coordination
  - Resource management

- **Process Engineering**
  - Clinical workflow analysis
  - Impact forecasting
  - Implementation planning

- **Data Analysis**
  - Data extraction
  - Performance evaluation
  - Dashboard management

- **Clinical Informatics**
  - EHR optimization
  - Clinical decision support creation

- **Clinical Education**
  - Education plan development
  - Communication strategy guidance

Source: Nursing Executive Center interviews and analysis.
There are two key points to remember when assembling a team for care standard design. The first is that each team member does not have to match to a single area of expertise. In fact, one person may have expertise across multiple areas. As long as all five areas of expertise are represented, you should build your team in the way that aligns best with your existing capacity. In this diagram, we show examples of the different ways four organizations staffed their design teams to encompass each of the five core skills.

The second point to remember is that designated does not mean dedicated. Even though all five areas of expertise are essential to care standard design, they do not all have to be full time. Design team members at Banner Health contribute different amounts of time, depending on their role. For example, Banner’s informaticists spend only half of their time working with care standard design teams, and the rest of their time is spent working on other projects throughout the system.

Design Team Roles at Four Organizations

<table>
<thead>
<tr>
<th>Organization</th>
<th>Project Management</th>
<th>Process Engineering</th>
<th>Data Analysis</th>
<th>Clinical Informatics</th>
<th>Clinical Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Banner Health</td>
<td>Program Director</td>
<td>Process Engineer</td>
<td>Data Analyst</td>
<td>Informaticist</td>
<td>Clinical Educator</td>
</tr>
<tr>
<td>MultiCare Connected Care</td>
<td>Program Coordinator</td>
<td>OE¹ Consultant</td>
<td>Data Consultant</td>
<td>Informaticist</td>
<td>Clinical Educator</td>
</tr>
<tr>
<td>Carolinas HealthCare System</td>
<td>Quality Outcomes Specialist</td>
<td>Data Analyst</td>
<td>Informaticist</td>
<td>Quality Outcomes Specialist²</td>
<td></td>
</tr>
<tr>
<td>University Hospitals</td>
<td>Operational Engineer</td>
<td>Financial Analyst</td>
<td>Informaticist</td>
<td>Informaticist</td>
<td>Clinical Educator</td>
</tr>
</tbody>
</table>

Designated Does Not Mean Dedicated

Banner’s Design Team Members Dedicate Varied Amounts of Time

- 20% Time: Clinical educators
- 30% Time: Process engineers
- 50% Time: Informaticists
- 100% Time: Program managers, Data Analysts

Case in Brief: Banner Health

- 29-hospital, not-for-profit system headquartered in Phoenix, Arizona
- Clinicians designing care standards are supported by wraparound support tagged to their project, including: informatics staff, clinical educators, clinical performance assessment and improvement staff, program directors, and process engineers

Sources: Banner Health, Phoenix, AZ; MultiCare Connected Care, Tacoma, WA; Texas Health Resources, Dallas-Fort Worth, Texas; Carolinas HealthCare System, Charlotte, NC; University Hospitals, Cleveland, OH; Nursing Executive Center interviews and analysis.

1) Organizational effectiveness.
2) Quality outcomes specialists work with clinicians on the team and additional subject matter experts to design education plans.
3) Financial analysts support the operational engineers in identifying and quantifying the cost savings during the design phase.
Although assembling a design team with all five areas of expertise may seem difficult, most organizations already have experts in the five core skills and don’t need to resort to external hiring. We recommend conducting an internal assessment to identify your internal talent. Some common places to look include: the performance improvement office, information technology department, and clinical leadership committees.

**Design Team Talent Hiding in Plain Sight**

**Common Places to Start Your Search**

- Performance improvement office
- Business office
- Information technology department
- Quality department
- Clinical leadership
- Clinical education department

Source: Nursing Executive Center interviews and analysis.
If you don’t have a deep bench of project managers, you can train select nurses to become project managers. At University Hospitals, the Department of Operational Effectiveness started a two-year fellowship for nurse managers interested in leading workflow redesign initiatives.

Through this program, nurses are trained in process engineering, then become full-time project managers in the Department of Operational Effectiveness. If these nurses wish to return to nursing, they are able to move into clinical leadership roles and can teach their own staff about project management.

Training Nurses to Lead Care Standard Design

Building Expertise from Within the Nursing Ranks

University Hospitals’ Department of Operational Effectiveness (DOE) Nurse Fellowship

Apply to DOE
- Nurses with interest in process engineering apply to fellowship
- Applicants are nurse managers or have previous experience in process improvement

Participate in Training
- Attend intensive training course on lean management through Kent State University
- Trained in analytics, business concepts, clinical operations, and workflow redesign

Join Design Team
- Spend two years working full-time in DOE
- Manage improvement projects throughout the system

Transfer to Leadership
- Take on clinical leadership position within the system
- Cascade lean training throughout their department

Nurses bring a different level of knowledge to this process. Our operational engineers are analytically strong and talented at their work, but the nurses bring a new perspective and help them fine-tune the interpersonal skills needed to drive this work.”

Ken Turner, VP Operational Effectiveness, University Hospitals

Case in Brief: University Hospitals

- 15-hospital health system headquartered in Cleveland, Ohio
- Created a nurse fellowship program in the Department of Operational Effectiveness for nurses interested in process engineering
- Fellowship was developed because design experts were struggling with communicating new standard information and the nurse perspective wasn’t fully represented during standard design
- Nurses spend two years working full-time in the department, where they receive training in analytics, business concepts, clinical operations, and workflow redesign to reduce variation
- Following the fellowship, nurses typically take on leadership positions throughout the system, where they continue to partake in High Reliability Medicine initiatives and cascade the concepts of lean training throughout their department
- Out of the five nurses who have gone through the program so far, two went on to become CNOs

Source: University Hospitals, Cleveland, OH; Nursing Executive Center interviews and analysis.
Component 2: Appoint a dedicated project manager to lead the design team

The second component of this tactic is to appoint a dedicated project manager.

The project manager is the most critical member of the design team and should be dedicated to design work full-time. The project manager’s responsibilities include: regularly informing key stakeholders, facilitating effective group discussion during team meetings, and fostering the relationships needed to gather necessary input.

Project Manager Is Most Critical Design Team Member

Project Managers Facilitate Teamwork to Ensure Goals are Achieved

- Sets team timeline, including a clear end goal and intermittent milestones
- Tracks progress and identifies and addresses potential barriers that will impede design work
- Reports to steering committees and debriefs executives regularly
- Cultivates relationships with executives, clinicians, and other quality leaders across the system
- Serves as a neutral voice to facilitate debate within working groups
- Acts as a spokesperson across system on improvement efforts

We hire for the talent of being able to grow grass without water, people who can design and invent a next step very naturally."

Pamela Beckwith, SVP Quality, Carolinas HealthCare System

"It’s about project management, leadership, and—most importantly—selling people on new ideas."

Ken Turner, VP Operational Effectiveness, University Hospitals

Source: Nursing Executive Center interviews and analysis.
Templatize a Design Team Charter

Keep in mind that you don’t need to reinvent the wheel each time you assemble a design team. Each team shouldn’t have to figure out their roles, expected time commitment, and goals from scratch. Instead, progressive organizations create a design team charter template to guide each team’s work. Stock components of an effective design team charter include: team purpose, membership roster, goals and outputs, and meeting protocols.

**Top Charter Benefits**
1. Clarifies team’s purpose and goals
2. Establishes expected time commitment
3. Streamlines meeting procedures
4. Prompts team to proactively consider stakeholders

**Example charters from Parker Adventist and RWJ Barnabas are available at advisory.com/nec**

**Design Team Charter**
1. Purpose
2. Membership
3. Goals and Outputs
4. Meeting Protocols
5. Impacted Stakeholders

**Optional Components:**
- Organizational chart
- Design assumptions
- Decision-making process

**Case in Brief: Parker Adventist**
- 170-bed hospital in Parker, Colorado; part of Centura Health System
- Uses a standardized team charter template and customizes it for each of their 14 service line-specific councils creating care standards
- Charter template includes team purpose, membership and support, responsibility and authority, decision-making rights, meeting cadence, meeting protocols, accountabilities for the council and chairs, and review of the charter

**Case in Brief: RWJ Barnabas Health**
- 11-hospital health system headquartered in West Orange, New Jersey
- Created team charters to direct the work of each of their 20+ system-level strategic committees involved in creating care standards
- Most charters emphasize the importance of cost savings
- As an example, their OB subcommittee charter details membership, team objectives, scope and boundaries, expected outcomes, and team resources

Source: Parker Adventist, Parker, CO; RWJ Barnabas Health, West Orange, NJ; Nursing Executive Center interviews and analysis.
Tactic 5: Enabler Identification

Tactic in Brief
Before implementing a care standard, proactively identify situations where the new workflow deviates significantly from the existing workflow. The goal is to pinpoint where clinicians are most likely to struggle during rollout and to proactively embed supporting resources—called enablers—at those points to help clinicians adapt to the new care standard.

Rationale
Implementing a new standard often requires clinicians to change their daily practice, which can be difficult. By embedding enablers (technologies, processes, or people) at critical moments where clinicians are most likely to go off track, leaders can make it easier for frontline staff to consistently adhere to a new workflow.

Implementation Components
Component 1: Identify where new and existing workflows differ
Use a robust process map to pinpoint when the new standard will significantly different from current practice.

Component 2: Embed enablers to ease adoption
Ensure that at each step where the new care standard will significantly differ from current practice, the design team embeds a supporting enabler. Enablers can be a person, technology, or process that will make it easier for frontline clinicians to follow the standard.

Tactic Assessment
This is an effective tactic for supporting clinicians in adopting new workflows, especially when a new care standard is dramatically different from current practice. Leaders can ease adoption at the front line by dedicating time during care standard design to embed enablers at critical process steps. While changing the process-mapping approach and adding enablers requires a modest amount of time and resources, the return warrants an investment.
While process maps are useful tools for depicting workflow, they often don’t account for the changes that will happen in the day-to-day experiences of clinicians responsible for carrying out new care standards.

For example, a sepsis protocol may require clinicians to administer antibiotics within three hours of a SIRS (system inflammatory responsive syndrome) positive result. But if there is no way for clinicians to be alerted about SIRS positive results in real time, they may not be able to meet the recommended standard of care.

Shifting from an output-driven perspective to a design-driven perspective prompts leaders to consider the “how,” in order to create more intuitive, actionable standards for clinicians to follow.

Process Maps Alone Not Enough to Drive Change

Protocols Not a Silver Bullet

"People say, ‘Here’s a map and a protocol, you’re good to go.’ But that’s not how this works. You can put a protocol in a workspace, but who cares? What people really need to know is how this new process will change their day-to-day.”

Jen Dawson
Operational Engineer, University Hospitals

A Design-Driven Approach to Care Standard Creation

Balancing the “What” with the “How”

Output-Driven Perspective

<table>
<thead>
<tr>
<th>Standard Creation</th>
<th>Diagnosis</th>
<th>Consultation</th>
<th>Treatment</th>
<th>Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>What steps need to be taken?</td>
<td>Draw serum lactate levels for every SIRS(^1) positive patient</td>
<td>Draw two blood cultures after antibiotics are administered</td>
<td>Administer antibiotic within three hours of SIRS positive</td>
<td>Adjust antibiotic based on blood culture results</td>
</tr>
</tbody>
</table>

Design-Driven Perspective

<table>
<thead>
<tr>
<th>Standard Creation</th>
<th>Diagnosis</th>
<th>Consultation</th>
<th>Treatment</th>
<th>Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>How can we ensure steps take place?</td>
<td>Do all units have adequate lactate tubes and request forms available?</td>
<td>Can the lab meet a 48-hour turnaround time with existing capacity?</td>
<td>Are clinicians alerted to SIRS positive result in real time?</td>
<td>Is an antibiotic cheat sheet available in EHR for clinicians to reference?</td>
</tr>
</tbody>
</table>

1) Systemic inflammatory response syndrome.

Source: Nursing Executive Center interviews and analysis.
Component 1: Identify where New and Existing Workflows Differ

The first component of this tactic is to identify where new and existing workflows differ by building a robust process map.

Texas Health Resources (THR) enhanced their process maps to pinpoint steps where existing workflow is most impacted by a new standard. As THR’s design team draws a process map, they pause at each step, note what role is responsible for that step, and assess any potential barriers that would make it challenging for the owner to transition from one step to the next.

At right is an excerpt of THR’s Supportive and Palliative Care Process Map.

---

Robust Process Maps Include Workflow Enablers

Texas Health Resources’ Supportive and Palliative Care Process Map

1) This is an excerpt from a working draft of THR’s full palliative care pathway.

Each Process Step Shows:
- Who/what role is responsible
- Enablers required to make the step reliable

Case in Brief: Texas Health Resources
- 29-hospital health system with more than 5,500 affiliated physicians; headquartered in Dallas-Fort Worth, Texas
- In 2015, deployed the Reliable Care Blueprinting™ initiative at all 18 acute-care hospitals to reduce unwarranted variation through care redesign
- During care standard design, teams create robust process maps including who is responsible for each process step and what enabler is required to make the process step reliable
- Multidisciplinary teams work to build and deploy all identified enablers

Source: Texas Health Resources, Dallas-Fort Worth, TX; Nursing Executive Center interviews and analysis.
Component 2: Embed enablers to ease adoption

The second component of this tactic is to embed enablers at steps where existing workflow is most impacted.

Enablers are the people, processes, and technologies that help ensure the step is completed reliably. As THR comes across significant barriers to new workflow adoption, they note what type of enabler may be needed to make it easier for clinicians to comply. This approach is called concurrent enabler identification.

Embedding an enabler doesn’t always require building a new resource; often the enabler already exists in the organization. For example, in this snapshot of THR’s process map for ED sepsis care, process engineers repurposed an existing alert for their ED assessment module.

THR Identifies Enablers for Every Process Step

Snapshot of Texas Health Resources’ Process Map for ED Sepsis Care

Example Enablers

Source: Texas Health Resources, Dallas-Fort Worth, TX; Nursing Executive Center interviews and analysis.
To help design teams identify enablers, give them a starter set of questions that explores how staff will accomplish each step of a given care standard. Nursing teams can also incorporate these questions into existing Kaizen or rapid improvement events.

Think Expansively About Workflow Enablers

Common Questions for the Design Team to Consider

**EHR Capabilities**
- Does the step need an alert?
- Is there a field in the EHR to document the step?
- Does the step need to be codified in an order set?

**Supplies**
- Are equipment and supplies available in the facility?
- Are clinicians and staff able to get the required equipment and supplies when they need them?

**Information**
- Do clinicians need a guide or checklist to do the step correctly?
- Do clinicians need information from another department to do the step?

**People**
- Does anyone need to be present to supervise the step?
- Does another person or department need to sign off on the step?
- Does the facility or unit have the personnel to do the step?

Source: Nursing Executive Center interviews and analysis.
Northwestern Memorial Central DuPage Hospital dramatically improved their adherence to their fall prevention bundle by considering how staff would implement each step of a new ambulation protocol.

Northwestern Memorial found that clinicians were not using gait belts to ambulate patients, resulting in patient and staff injuries. Even though the standard existed, adherence did not occur until after the nursing team at Northwestern asked how to keep gait belts in every room, how to make sure clinicians were reminded to use the belts during their daily work, and how to make sure environmental services knew when to replace used belts and keep them stocked.

Northwestern Memorial’s efforts to explore how they could enable gait belt use allowed clinicians to follow the standard, while significantly reducing patient falls and avoiding staff frustration.

Improving Standards by Investigating the “How”

Northwestern Memorial Central DuPage Hospital’s Fall Prevention Tactic

Enabler Identification: How can we safely ambulate?

1. Physical therapy: Gait belts should be used
2. Nursing: We need gait belts in every room
3. Facilities: Hang belts visibly in every room
4. Environmental services: Ensure laundered gait belts are hanging in every room following room cleaning

Case in Brief: Northwestern Memorial Central DuPage Hospital

• 392-bed community hospital in Winfield, Illinois
• Created a nurse-led interdisciplinary falls prevention bundle to support earlier ambulation time for post-surgical patients
• The falls bundle lists out the ambulation protocol for patients who are low, medium, and high fall risk (but initially included information only on what to do, not how to do it)
• The nursing team struggled to follow one of the new fall bundle elements because gait belts weren’t placed in every room for use; this prompted the CNO to proactively determine how the organization could ensure gait belt access in every room
• By involving staff from environmental services, facilities, and physical therapy, they were able to develop and deploy a strategy to keep gait belts visible in all patient rooms
• The protocol resulted in increased use of gait belts, which helped prevent falls during ambulation
• The falls prevention bundle resulted in a decrease from 3.26 falls/1,000 patient days in 2012 to 1.13 falls/1,000 patient days in 2016

Source: Northwestern Memorial Central DuPage Hospital, Winfield, IL, Nursing Executive Center interviews and analysis.
Tactic 6: Rollout Readiness Assessment

**Tactic in Brief**

Proactively determine which tools, technologies, and/or personnel individual facilities need to adopt a new care standard. The goal is to identify barriers to implementation so design teams can either provide facilities with additional support or revise the care standard before rolling it out.

**Rationale**

Implementation barriers often aren’t surfaced until after the design team has completed a care standard and rolled it out. As a result, when implementation barriers arise, each facility must scramble to solve challenges on their own. This can lead to low adherence post-rollout because implementation leaders lack the time or resources needed to adequately address the barriers sufficiently.

By identifying facility-level implementation barriers before rollout, design teams have the opportunity to revise care standards in a way that alleviates universal barriers. Additionally, facilities have adequate time to prepare for localized barriers.

**Implementation Components**

**Component 1: Measure each facility’s readiness to implement the standard before rollout**

Review the new care standard to at least six weeks before rollout to determine if each facility has the necessary resources to adhere to the new standard, and identify potential barriers unique to certain locations. Facility-level leaders can complete this assessment or design teams can complete it.

**Component 2: Decide if facilities need individual support or if the care standard should be revised**

Use the results of the readiness assessment to identify trends. If a small number of facilities need additional support before rolling out the care standard, the design team should provide additional support or enablers on a one-off basis. In cases where multiple facilities need additional support, the design team should consider redesigning the care standard.

**Tactic Assessment**

We recommend this tactic for systems that are rolling out the same care standard across multiple facilities to assess each location’s level of preparedness. The readiness assessment is an easy-to-use tool that will help design teams proactively address potential implementation challenges.

This tactic can easily be adapted for use in individual or stand-alone facilities that are rolling out the same care standard across multiple units or departments. Facility-level leaders can follow the same components to assess the readiness of individual units or departments to implement a new care standard.

Source: Nursing Executive Center interviews and analysis.
The most effective design teams account for the fact that some facilities will struggle to adopt a new care standard more than others. That’s because some facilities’ current practices will already be aligned with the new care standard—while other facilities will need to change their practices more significantly.

Evaluate Readiness to Implement

.Measure How Your Current Practice Stacks Up

Ready to implement
- Has equipment and supplies
- Minor EHR changes needed
- No new information or training required

Not Ready to Implement
- Does not have equipment and supplies
- Major EHR changes needed
- New information or training required

“Figuring out how a standard is going to work in an academic medical center with 900 beds compared to a community hospital that only has nine beds is a huge challenge.”

Vice President, Large Health System in Midwest

Source: Nursing Executive Center interviews and analysis.
Component 1: Measure each facility’s readiness to implement the standard before rollout

The first component of this tactic is to proactively measure each facility’s readiness to implement the standard. At least six weeks before the scheduled care standard rollout, send the finalized care standard to each facility, along with a readiness assessment for facility leaders to complete.

Shown here is a condensed and collated version of Texas Health Resources’ (THR) CABG readiness assessment. At the top of the assessment, THR lists each step of the new care standard. To help leaders anticipate barriers, THR specifies how facilities can embed each component into their existing workflow. THR asks a leader at each facility to rate their readiness on a three-point scale, where 1 indicates that the facility is already compliant with the step, and 3 suggests that a total process change is required.

Assessing Facility Readiness at Each Process Step

Sample Items from THR’s Collated CABG¹ Inventory

<table>
<thead>
<tr>
<th>Hardwiring Care Standard</th>
<th>Identify anticipated discharge disposition</th>
<th>Confirm beta blocker taken within 24 hours</th>
<th>Provide smoking cessation counseling when appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital 1</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Hospital 2</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Hospital 3</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

THR Standard Readiness Scale
1 = Already compliant
2 = Understand expectation, not complete
3 = Brand new, will require process change

Facilities scoring 2 or 3 can request specific enterprise support

Case in Brief: Texas Health Resources

- 29-hospital health system with more than 5,500 affiliated physicians; headquartered in Dallas-Fort Worth, Texas
- In 2015, deployed the Reliable Care Blueprinting™ initiative at all 18 acute-care hospitals to reduce unwarranted variation through care redesign
- To assess individual hospital readiness for standard rollout, system sends impact inventories to all affected hospitals 12 weeks prior to rollout
- Inventories require hospitals to rate on 3-point scale level of preparedness for each clinical specification
- Inventories completed and collated, analyzed across all hospitals, lead to action plan (individual or system-level discussion)
- When hospitals indicate lack of readiness, system-level design team analyzes necessary modifications or support (e.g., for pre-operative five-meter walk test, training additional staff to perform walk tests)

¹ Coronary artery bypass grafting.
Component 2: Decide if facilities need individual support or if the care standard should be revised

The second component of this tactic is to review the readiness assessments and decide if facilities need individual support, or if the care standard itself should be revised.

After collecting each facility’s readiness assessment, look for trends across facility responses. THR has determined two possible outcomes of this review. If multiple hospitals indicate lack of readiness, a system-level discussion follows and the design team may revise the standard to better align with current workflow. Alternatively, if a smaller subset of hospitals indicate lack of readiness, the discussion occurs at the hospital level and the design team considers ways to support the specific facilities.

Mapping Assessment Results to Right Response

Texas Health Resources’ Impact Inventory Timeline

**Six Weeks Before Launch**
Assessments sent to each hospital in the system

**Two Weeks Before Launch**
Facility implementation leads send completed inventory to enterprise

**Enterprise Standard Complete**
Every hospital indicates level of preparedness for each clinical specification on a 3-point scale

**Enterprise analysis of responses collected from all impacted hospitals**

**Scenario 1**
Multiple hospital scores indicating lack of readiness trigger enterprise-level discussion

**Scenario 2**
Scores indicating lack of readiness at individual hospital trigger hospital-level discussion

Source: Texas Health Resources, Dallas-Fort Worth, TX; Nursing Executive Center interviews and analysis.
Assessments Can Identify a Cross-Hospital Need

Case in Point: Staffing the Pre-Operative Five-Meter Walk Test

Requirement Introduced
CABG care standard requires 5-meter walk test for every pre-operative patient

Gap Revealed
Assessments from several smaller hospitals reveal that some facilities don’t have the necessary staff trained on walk tests

Solution Proposed
System decides to offer staff education at smaller facilities on how to conduct walk tests

“The ability for users to provide a narrative description of barriers helps us to identify themes that may require a system-level action plan versus a local entity issue that will require an individualized approach.”

April Adams, Program Director, Heart & Vascular Service Line, Texas Health Resources

Source: Texas Health Resources, Dallas-Fort Worth, TX; Nursing Executive Center interviews and analysis.
Sentara Healthcare conducts a readiness assessment for all new care standards and asks design teams to fill it out, rather than facility-level leaders. Using a version of the form shown here, design teams at Sentara confirm that the necessary technologies, training, and information will be in place at each impacted facility before a care standard is scheduled for rollout.

Audit Readiness of Design Teams’ Plans

Excerpt from Sentara’s Intake Form

<table>
<thead>
<tr>
<th>Project Scope</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impacted locations, departments, units</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Timeline and Project Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>IT/EHR changes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Plan and timeline for alerting stakeholders</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Educational components and when they’ll be ready</th>
</tr>
</thead>
</table>

Design Team Must:

1. Indicate all locations and departments impacted by the new care standard
2. Estimate timeline required for rollout
3. Evaluate readiness of required equipment, supplies, EHR changes, and education plans

Case in Brief: Sentara Healthcare

• 12-hospital health system, headquartered in Norfolk, Virginia
• Created a Clinical Queuing Committee to determine the schedule for rolling out new standards and other clinical initiatives across the system
• The project lead from each design team submits an intake form to the queuing committee
• The intake form asks project leads to provide information about the project scope (i.e., all impacted locations, jobs/roles, and departments) and the project plan (i.e., the timeline, needed supplies/technology, communication, and education plans—and if those elements are in place)
• If the project is not complete, the project team will be notified that they must revise the new standard, policy, or project before rollout
• Typical criteria that indicates a project should be revised includes: missing an education plan, technology that won’t be ready in time, overlooking certain facilities that will be impacted, or conflicts with existing standards

Source: Sentara Healthcare, Norfolk, VA; Nursing Executive Center interviews and analysis.
A Clinical Queuing Committee, which includes the system CNO, frontline clinicians, and operational leaders, meets once a month to review completed assessments and determine next steps. Similar to the practice at THR, Sentara has determined two possible outcomes of this review. If the Clinical Queuing Committee identifies that a critical aspect of rollout hasn’t been addressed, the form is sent back to the design team for revision. If the rollout plan sufficiently supports all impacted facilities, the care standard is ready to be implemented.

Even though most care standards are ready for rollout by the time they reach the Clinical Queuing Committee, this process gives leaders at Sentara an efficient way to catch and address any implementation barriers that do arise.

### Catching Needed Revisions Before Rollout

**Sentara’s Process for Reviewing New Standards**

**Grounds for Project Revision:**
- Does not include an education, communication, or implementation plan
- Overlooks impacted facilities
- Does not account for facility-level differences, such as EHR variation
- Conflicts with existing policies or standards

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Source: Sentara Healthcare, Norfolk, VA; Nursing Executive Center interviews and analysis.
► Provide Enterprise-Level Rollout Support

- Tactic 7: Implementation-Ready Toolkit
- Tactic 8: Facility Implementation Lead
- Tactic 9: Enterprise-Wide Change Calendar
Many organizations lack a system-wide process for rolling out new care standards. Often, when a new care standard is ready for implementation, individual facilities or units are expected to lead the rollout themselves.

There are two risks with this siloed approach. The first risk is that it can create duplicative work across the system. Leaders spend time solving challenges that others have already solved elsewhere in the system. These redundancies can create variation in how clinicians follow the care standard from the onset. The second risk of siloed rollout is that too many care standards can be rolled out at once, creating an overwhelming pace of change at some facilities.

To avoid these risks, organizations should provide enterprise-wide rollout supports. The first two tactics in this section will help prevent duplicative work across the system, and the third tactic will help ease the pace of new care standard rollouts.

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**Siloed Rollout Undermines Standardization**

**Two Common Risks at Rollout**

1. **Duplicative Work Across Enterprise**

   - Each facility or unit creates own communication and rollout plan
   - Clinical leaders solve the same issues on their own

2. **Overwhelming Pace of Change**

   - Different design teams and CCGs¹ launch standards at the same time
   - Care standard rollout occurs at the same time as other priority initiatives on the unit

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**Representative Facility Feedback**

- “It’s really hard to have everyone aligned…a standard way to implement standards would be good.”
- “Can’t we figure this out once, together, for the whole system?”

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1) Clinical Consensus Groups.

Source: Nursing Executive Center interviews and analysis.
Tactic 7: Implementation-Ready Toolkit

Tactic in Brief
Create a toolkit to guide care standard design and implementation. The goal is to provide clear implementation guidance that is uniform and comprehensive across the organization.

Rationale
Few organizations provide clear guidance about what a care standard should include or how to implement it across the organization. As a result, care standards can vary widely across design teams. A standardized toolkit template gives design teams a roadmap to design consistent standards. Additionally, clinicians often find that they lack information on how to integrate new care standards into their daily work. The completed toolkit serves as an important frontline implementation guide.

Implementation Components
Component 1: Create an organization-wide toolkit template
Determine what clinical and non-clinical information is needed to roll out and implement a care standard, such as communication plans and training materials. The content included in the template should be relevant regardless of the clinical area and focused on facilitating implementation at the front line.

Component 2: Introduce and reinforce the toolkit organization-wide
Widely distribute the implementation toolkit template to anyone involved in care standard design and electronically post the template in an accessible location. Recruit internal leaders to communicate the value of the toolkit and to ensure that everyone in the organization knows that care standards will not be approved unless the entire toolkit has been completed. Communicate to clinicians where they can access all completed implementation toolkits by keeping them up-to-date in a shared folder or on the organization intranet.

Tactic Assessment
We recommend this tactic for organizations that do not have a standardized way of codifying new care standards or communicating them to frontline clinicians. Creating an implementation toolkit from scratch can be time consuming, so we recommend using the Nursing Executive Center’s customizable Toolkit for Building Implementation-Ready Care Standards.

Source: Nursing Executive Center interviews and analysis.
Without clear guidance, design teams often produce widely varying outputs for new care standards. While all teams will likely include clinical specifications, one team may identify performance measures to monitor care standard compliance, another team may create education materials, and a third team may do neither. This is problematic because each team is “re-inventing the wheel” for each new care standard, and frontline caregivers do not receive consistent materials to help them adopt new standards.

**Inconsistent Materials Make Rollout Harder**

**Final Outputs Look Different Across Design Teams**

**Design Team A**
- Clinical specifications
- New order sets
- Redesigned workflow

**Design Team B**
- Clinical specifications
- Education materials
- Redesigned workflow

**Design Team C**
- Clinical specifications
- Redesigned workflow

**Design Team D**
- Clinical specifications
- Performance measures
- New EHR alert

**Component 1: Create an organization-wide toolkit template**

The first component of this tactic is to create an organization-wide toolkit for new care standards.

As shown on the right, an implementation toolkit serves two important purposes. First, at the system level, it guides the design team’s work by outlining every component of a complete care standard.

Second, the toolkit serves as a guide for facilities during rollout. For example, the toolkit provides guidance about workflow changes and gives leaders the necessary training materials needed to educate their staff about the new standard.

**Toolkit Unites Design and Implementation**

**Implementation Toolkit Dual Purpose**

- **Enterprise-Level Design**
  - **Care Standard Template**
    - Toolkit acts as a template listing all components of a care standard that need to be addressed
    - Completing the toolkit signifies that care standard design is complete

- **Implementation Guide**
  - Toolkit acts as primary implementation mechanism, listing all the training and workflow changes necessary to implement the standard
  - Following toolkit guidance ensures uniform implementation

1) Electronic health record.
Banner Health uses a system-wide implementation toolkit template that includes five sections: clinical specifications, implementation plan, communication plan and materials, education plan and materials, and a performance monitoring plan. The toolkit also includes specific guidance on how design teams should complete each section.

### Comprehensive Toolkit Drives Implementation

**Banner Codifies Standards in a User-Friendly Format**

<table>
<thead>
<tr>
<th>Clinical Specifications</th>
<th>Implementation Plan</th>
<th>Communication Plan and Materials</th>
<th>Education Plan and Materials</th>
<th>Performance Monitoring Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Executive summaries limited to one page</td>
<td>• Implementation lead roles and responsibilities</td>
<td>• Communication plan overview including the who, when, how, and with what</td>
<td>• Overview of key stakeholders and education goals</td>
<td>• Defined baselines and performance expectations</td>
</tr>
<tr>
<td>• Supporting documents include clinical specifications and process map</td>
<td>• Contact information for every lead</td>
<td>• Detailed communication materials tailored to stakeholders</td>
<td>• Education materials tailored to individual stakeholders</td>
<td>• Links to performance dashboards</td>
</tr>
<tr>
<td>• Implementation tracker listing all action steps</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Case in Brief: Banner Health

- 29-hospital, not-for-profit system headquartered in Phoenix, Arizona, with facilities in Arizona, Alaska, California, Colorado, Nevada, Nebraska, and Wyoming
- In the early 2000s, Banner committed to system-wide clinical standardization as a means to improve quality and reduce unnecessary care utilization
- The design phase of care standard development culminates in an implementation toolkit that drives the implementation of standards at each of the 29 facilities within the system
- The toolkit includes: justification for the care standard, the clinical specifications, a process map, implementation steps, education and communication plans, education and communication materials, and a dashboard to measure results
- Toolkits are kept on a single SharePoint for all staff to access

Source: Banner Health, Phoenix, AZ; Nursing Executive Center interviews and analysis.
University Hospitals (UH) uses an implementation toolkit template that has stock sections pre-populated by UH’s High Reliability Medicine leadership team. The stock sections include directions to access scorecards and an overview of accountability structures. These remain the same for all care standards. UH’s design team leaders must update the initiative summary, performance metrics, and implementation action items before rolling the care standard out to facilities.

### University Hospitals’ Facility Implementation Template

**Stock Sections**
- Introduction to High Reliability Medicine
- Review of system- and facility-level governance
- Directions to access initiative scorecards

**Initiative-Specific Sections**
- Initiative summary including benefits to system and patients
- Review of performance metrics, thresholds, and targets
- List of implementation action items including scheduled education sessions

**Template Benefits**
- Ensures all standards are complete before implementation
- Safeguards against inconsistent standards
- Provides high-level education on care standards
- Serves as a guide for facility implementations

### Case in Brief: University Hospitals
- 15-hospital health system headquartered in Cleveland, Ohio
- In 2015, system leaders launched the High Reliability Medicine (HRM) initiative to provide safe, evidence-based, and effective care that drives out unnecessary variation and creates value
- The HRM initiative is broken down into three distinct phases: an 8-12 week design phase, an 8-12 week implementation phase, and an ongoing maintenance phase
- System leaders created a five-part implementation guide template that is completed by every design team; templates include an introduction to HRM, the HRM condition and care standard(s) summary, implementation guidance (key steps, performance indicators, education and training outlines), scorecard guidance, and governance overview
- System saw over $15 million in revenue improvement and cost savings, and significant improvement in mortality and readmission for condition-specific HRM initiatives

Source: University Hospitals, Cleveland, OH; Nursing Executive Center interviews and analysis.
Promote Toolkit Organization-Wide

Two Critical Steps Ensure Toolkit Is Utilized

**Distribute to Design Teams**
- Send the implementation toolkit to everyone involved in care standard design

**Ensure Easy Access**
- Store the toolkit on an easily accessible site, such as SharePoint; consider other channels, such as signs in common areas

**Require Compliance with Format**
- Communicate that all new standards must follow the toolkit be approved

**Cultivate Clinician Buy-In**
- Recruit clinician champions to speak to the value of the implementation toolkit

---

**Introduce Widely**

**Reinforce Consistently**

For more information and customizable templates, download the Toolkit for Building Implementation-Ready Care Standards at advisory.com/nec

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Component 2: Introduce and reinforce the toolkit organization-wide

The second component of this tactic is to introduce the toolkit across the organization, and to reinforce it regularly.

The toolkit should be sent to everyone working on care standard creation at your organization and made easily accessible. Consider distribution points such as a shared drive, email, and signs in common areas.

Clinical leaders must hold design team leaders accountable for ensuring all new standards are submitted in the format laid out by the implementation toolkit. Prepare leaders to educate staff on how a standardized format will benefit patients.

Early on, it may be helpful to recruit champions from around the organization to reinforce the value of completing the implementation toolkit. These champions should be able to emphasize how the toolkit will ultimately benefit clinicians.

Source: Nursing Executive Center interviews and analysis.
Tactic 8: Facility Implementation Lead

Tactic in Brief
Designate a single leader to oversee implementation of all new care standards at a facility. The goal is for a single leader to develop expertise and efficiency in care standard implementation.

Rationale
Most organizations spread the responsibility for care standard implementation across multiple leaders. The rationale is to lessen the burden on any one leader, but the downside to this approach is that each leader has to re-invent the wheel and discover how to best implement new care standards. This reduces efficiency and increases the likelihood that important details fall through the cracks.

An added benefit of having a single leader oversee implementation of all new care standards is that it simplifies communication between facilities and the system office.

Implementation Components

Component 1: Identify a highly effective facility implementation lead
Select a facility implementation lead who is an effective communicator and easily builds relationships with clinicians and administration at their facility. The selected leader should receive dedicated time to devote to care standard rollout.

Component 2: Flag frontline concerns for the system design team
Facility implementation leads work directly with frontline clinicians to identify their questions and concerns about new care standards. Then, facility implementation leads elevate frontline concerns to the system design team. This allows the design team to gain insight into frontline clinicians’ reactions to upcoming changes and anticipate future challenges.

Tactic Assessment
We recommend this tactic for systems that frequently struggle with inconsistent roll out of care standards across facilities because it assigns clear ownership and accountability for rollout. This tactic likely requires reallocating responsibilities, but does not necessarily require investing in a new hire since shifting responsibilities will likely free up enough time for the implementation lead to focus on care standard implementation. In other words, this tactic is about concentrating responsibilities, not creating new responsibilities. Many organizations have found quality improvement leaders or administrative fellows are interested in serving as facility implementation leads.

Source: Nursing Executive Center interviews and analysis.
Most organizations ask multiple leaders to oversee care standard implementation. The rationale is that they can select leaders with relevant clinical expertise and avoid over-burdening any single person. The potential problem with this approach is that these leaders may not have the skills needed to successfully oversee care standard implementation—and each individual leader must re-learn key lessons and practices.

Progressive health systems select one person to oversee all care standard rollouts within a single facility. Alternatively, single-facility organizations can apply the same principle and select one person to oversee all care standard rollouts across units. The goal is to have a single leader consistently manage rollouts and become an expert in care standard implementation.

**Consistent Lead Helps Scale Standardization**

### Different Methods to Select a Lead

<table>
<thead>
<tr>
<th>Common Practice</th>
<th>Good Practice</th>
<th>Best Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>No implementation lead formally assigned</td>
<td>One implementation lead per standard</td>
<td>One implementation lead for all standards</td>
</tr>
</tbody>
</table>

“Where I see variation really goes back to the leader... It all starts with leadership and reducing leader variation. If you have leaders who are more engaged and hands-on and really able to understand the work environment, then you’re going to be more successful.”

CNO, 300-bed hospital in Southeast

Source: Nursing Executive Center interviews and analysis.
Component 1: Identify a highly effective facility implementation lead

The first component of this tactic is to select a single leader to oversee rollout of all care standards at a facility.

Organizational leaders should consider four characteristics when selecting a facility implementation lead. The first is a deep understanding of the facility to anticipate potential challenges. The second is strong communication skills and the ability to serve as an intermediary between facility- and system-level leaders. Third, the lead should have strong institutional relationships—and feel comfortable building new ones—to work with a wide range of stakeholders. Fourth, the lead should demonstrate accountability for implementation planning and reporting progress to the system design team.

Select the Right Person to Lead Implementation

Four Characteristics of a Facility Implementation Lead

- **Institutional Expert**
  Leads all standard rollouts at their facility; becomes well versed at implementation planning

- **Effective Communicator**
  Acts as liaison between facility- and system-level contacts; sets expectations for goals and next steps

- **Relationship Builder**
  Leverages relationships to assemble deployment teams within specialties impacted by standard

- **Accountable Leader**
  Dedicates time to implementation planning; reports progress and flags facility-specific challenges

Source: Nursing Executive Center interviews and analysis.
Component 2: Flag frontline concerns for the system design team

The second component of this tactic is to enable the selected facility implementation lead to flag frontline clinicians’ concerns for the system design team.

Texas Health Resources (THR) established a clear line of communication between facility implementation leads and the system-level design team to ensure that frontline concerns are elevated—and addressed—before rollout.

In the example shown here, THR launched a new surgical count standard in all its facilities. During planning, the implementation lead at one facility uncovered concern among clinicians that the new care standard would negatively impact turnover time and volumes. The facility implementation lead shared this concern with THR’s system-level design team.

In response, the design team decided to pause system-wide rollout and pilot the new standard at just two facilities. The pilot demonstrated the standard didn’t have a negative impact on turnover time and volumes. This data equipped facility implementation leads to directly address clinician concerns, and the design team was able to resume system-wide rollout.

Leadership Continuity Crucial to Successful Rollout Planning

“The benefit of having a standard point of contact at the facility level is that they develop a competency around what it means to deploy a standard and can anticipate how contentious a new standard will be. “This can be a heavy lift for someone with a day job, but establishing that continuity is incredibly important.”

Brandie Meyer
VP, Strategic Integration
Texas Health Resources

Case in Brief: Texas Health Resources

- 29-hospital health system with more than 5,500 affiliated physicians; headquartered in Dallas-Fort Worth, Texas
- In 2015, deployed the Reliable Care Blueprinting™ initiative at all 18 acute-care hospitals to reduce unwarranted variation through care redesign
- Created a facility-specific implementation lead role at every facility; implementation lead is responsible for completing the facility’s heat map, deploying care standards at their facility, collecting clinician feedback, and creating two-way communication with the system on care standard implementation
Tactic 9: Enterprise-Wide Change Calendar

Tactic in Brief
Executives track all change events on a single centralized calendar. The goal is to avoid change fatigue by re-sequencing overlapping initiatives—including rollout of new care standards—and helping staff anticipate upcoming changes.

Rationale
The rapid pace of change can be overwhelming to frontline staff, especially when changes that impact workflow are scheduled in close proximity. By strategically sequencing the launch of new change initiatives, including new care standards, leaders can minimize staff stress and burnout.

Implementation Components

Component 1: Schedule all planned changes on a single calendar
Create a single centralized calendar to strategically schedule and sequence upcoming clinical initiatives, including the rollout of new care standards.

Component 2: Use a multidisciplinary review group to maintain the calendar
A multidisciplinary review group meets regularly to review new initiatives and update the change calendar. The group should include executive leaders, frontline clinicians, IT experts, and operational managers. Organizations can use an existing group that includes these perspectives or create a new group explicitly for calendar management.

Component 3: Set ground rules for scheduling and sequencing changes
The review group adheres to established ground rules for how many changes can be rolled out at once, what types of changes can be rolled out together, and when to reschedule proposed changes.

Component 4: Provide advance notice of upcoming care standards to frontline staff
Clinical leaders share the change calendar with frontline staff so that clinicians understand the rationale and timing of each change.

Tactic Assessment
We highly recommend this tactic for all organizations, regardless of size. This tactic is an effective strategy for avoiding clinician burnout and increasing the likelihood that care standards are successfully implemented. While it requires considerable collaboration, the return is worth the effort. If it doesn’t seem feasible to pilot this at the system level, this tactic can be started at the department or facility level (and eventually scaled-up to include the entire system).

Source: Nursing Executive Center interviews and analysis.
Component 1: Schedule all planned changes on a single calendar

The first component of this tactic is to schedule all planned changes on a single calendar.

An excerpt of Sentara Healthcare’s centralized change calendar is shown here. The calendar includes all clinical initiatives that impact two or more facilities. For each of those initiatives, the calendar indicates the type of initiative and who is impacted. It also indicates pending initiatives that leaders still need to schedule.

Leaders at Sentara can easily spot times when multiple initiatives are scheduled and work to rearrange the calendar to reduce the amount of change at any given time.

Scale a Change Calendar Across the Enterprise

Sentara’s Enterprise-Wide Change Calendar

<table>
<thead>
<tr>
<th>New Standard</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Facilities &amp; Staff Impacted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Projects with approved rollout dates</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Product Administration Module</td>
<td></td>
<td>2</td>
<td></td>
<td>All clinicians</td>
</tr>
<tr>
<td>Bedside Barcode Specimen Collection</td>
<td></td>
<td></td>
<td></td>
<td>Nursing</td>
</tr>
<tr>
<td>Foley Protocol Revisions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pending projects – no rollout date</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall Prevention Expectations</td>
<td></td>
<td></td>
<td></td>
<td>Nursing</td>
</tr>
<tr>
<td>Emergency Alerts</td>
<td></td>
<td></td>
<td></td>
<td>All staff</td>
</tr>
</tbody>
</table>

Key Components for Scaling a Change Calendar

- Multidisciplinary review group
- Ground rules for rollout
- Advance frontline notice of upcoming changes

Case in Brief: Sentara Healthcare

- 12-hospital health system, headquartered in Norfolk, Virginia
- Created a multidisciplinary queuing committee that meets once per month to queue and schedule clinical initiatives impacting more than two facilities in the system; all initiatives scheduled on a system-wide change calendar
- Project leads submit a form to the queuing committee detailing what the project is; which locations, functions, and roles will be impacted; and what training, technology, and communication is needed for the change
- The committee strives to limit the pace of rollout to no more than two clinical initiatives at one time
- For example, Sentara had 23 projects ready for rollout between May and December of 2015; system staggered projects so that there were no more than two rolling out during any one week

Source: Sentara Healthcare, Norfolk, VA; Nursing Executive Center interviews and analysis.
Component 2: Use a multidisciplinary review group to maintain the calendar

The second component is to use a multidisciplinary review group to maintain the calendar. Maintaining a centralized calendar of this scale is too large of a task for one person to reasonably accomplish alone. Additionally, allowing multiple departments to review the calendar ensures that new care standards aren’t rolled out at inopportune times.

Sentara established a Clinical Queuing Committee to maintain their change calendar. The committee is led by the system CNO and includes frontline clinicians, IT leaders, and operational leaders. Collectively, the group has broad perspective into competing priorities across the system, which they take into consideration when scheduling new care standards for rollout.

Leverage a Multidisciplinary Review Group
Sentara Brings Diverse Roles, Ranks to the Table

Clinical Queuing Committee

- Representation from across the organization
- Meets monthly for 90 minutes
- Regular attendance is expected

Source: Sentara Healthcare, Norfolk, VA; Nursing Executive Center interviews and analysis.1) Electronic health record.

Sentara’s Queuing Committee Charter available at advisory.com/nec

Executive Leaders
Provide oversight and strategic guidance to sequence clinical initiatives

Frontline Clinicians
Speak to frontline concerns and bandwidth related to new standards

Technology and IT
Offer insight into technological capabilities and bandwidth

Hospital Operations
Flag where non-clinical departments will be impacted, and to what extent

1) Electronic health record.

Source: Sentara Healthcare, Norfolk, VA; Nursing Executive Center interviews and analysis.
Component 3: Set ground rules for scheduling and sequencing changes

The third component is to set ground rules for scheduling and sequencing changes. Two of Sentara’s ground rules are shown here. First, Sentara rolls out only two clinical initiatives at once. Leaders at Sentara follow this rule to ensure frontline caregivers aren’t overwhelmed by change and have ample time to learn new care standards. Second, Sentara bundles similar initiatives to roll out together to limit the number of times they pull clinicians off the floor for training.

Set Ground Rules for Rollout

Sentara Schedules Rollouts to Ease the Pace of Change

1. Only two clinical initiatives can roll out at once

   Both initiatives:
   - Have a completed rollout plan
   - Align with a strategic priority

   ![Diagram showing two initiatives being scheduled](image)

2. Similar clinical initiatives should roll out together

   Initiatives combined when they:
   - Are on related topics
   - Have similar goals
   - Require multiple small changes

   ![Diagram showing single training plan and CLABSI guideline](image)

Curos Tips

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1) Central line-associated bloodstream infection.

Source: Sentara Healthcare, Norfolk, VA; Nursing Executive Center interviews and analysis
Component 4: Provide advance notice of upcoming care standards to frontline staff

The final component of this tactic is to provide frontline clinicians with advance notice of upcoming care standards. Sentara provides advance notice by sending a monthly queuing email, which includes an excerpt of the system-wide change calendar and brief descriptions of upcoming changes.

Frontline clinicians at Sentara consider the monthly queuing email to be among the most valuable communications they receive, because it provides timely reminders and allows them to prepare for upcoming changes.

Give Advance Frontline Notice of Upcoming Change

Sentara Leaders Send System-Wide Queuing Email

Positive Staff Reactions

"I think the Queuing emails are great! With so much going on, it is a great reminder!"

"The Queuing emails are the most informative and useful emails we receive from Sentara."

Source: Sentara Healthcare, Norfolk, VA; Nursing Executive Center interviews and analysis.
Activate Frontline Nurses in Care Variation Reduction

- Tactic 10: Frontline Feedback Loop
- Tactic 11: Peer Coach Cohort
- Tactic 12: CVR Primer for Preceptors
Clinicians often discover implementation barriers well after a new care standard has officially rolled out. This page highlights the most common barriers to long-term care standard adoption. For example, a nurse who moves from one unit to another may not know if a care standard applies to a new patient population.

When clinicians come across one of these barriers, they may become frustrated and resort to workarounds, which leads to greater care variation, unless they have easy access to support. For this reason, organizations should provide ongoing implementation supports, even after the rollout phase for any new care standard.

This section provides three tactics organizations can use to help clinicians turn new care standards into long-term habits.

Frequent Feedback Counteracts Workarounds

Typical Progression into Workarounds

1) Electronic medical record

Common Barriers to Long-Term Adoption

New Situations
Clinicians are unsure how a standard applies to a situation that they haven’t come across before

New Employees
New hires have questions about existing standards that were implemented before their time

New Context
New developments or changes now make it difficult to follow existing standards

New Ideas
Clinicians identify insights that could improve existing and future standards, but those ideas aren’t captured

Source: Nursing Executive Center interviews and analysis.
Tactic 10: Frontline Feedback Loop

Tactic in Brief
Create a consistent channel for frontline clinicians to communicate with clinical leadership about new and existing care standards. The goal is to drive long-term adherence to care standards and prevent workarounds by giving clinicians an easy way to provide feedback and submit questions whenever they face an implementation barrier.

Rationale
Most organizations solicit frontline feedback and questions on new care standards during the rollout phase but fail to continue that dialogue over time. When clinicians face new implementation barriers over time—and lack a forum in which to address them—they often become frustrated and develop workarounds.

Implementation Components
Component 1: Leverage an existing communication channel to solicit ongoing feedback
Gather ongoing frontline feedback and questions on care standards using an existing communication channel; for example, virtually, during leader rounds, or in an existing meeting series.

Component 2: Routinely review and respond to all feedback and questions
Regularly review frontline feedback and questions. Decide whether feedback indicates a need for additional information, implementation support, or—in select cases—a revision of the original care standard.

Tactic Assessment
Organizations should implement this tactic only if they can commit to reviewing and providing timely responses to all frontline feedback and questions. Otherwise, this tactic runs the risk of frustrating and disengaging clinicians. We describe three different mechanisms to receive feedback; the channel is less important than consistently reviewing feedback and communicating resolutions directly to the clinicians who submitted it.

Source: Nursing Executive Center interviews and analysis.
Component 1: Leverage an existing communication channel to solicit ongoing feedback

The first component of this tactic is to leverage an existing communication channel to solicit ongoing feedback and questions on care standards. Importantly, the channel you choose should be one that already exists in clinicians’ workflow.

For example, nursing leaders at St. John’s Hospital, part of Hospital Sisters Health System, leveraged existing manager and director rounds—which St. John’s calls Connection Rounds—to gather frontline feedback on care standards.

Every month, the CNO creates a newsletter of updates on new policies and protocols. Nurse managers and directors use the newsletter as their talking points during rounds and ask nurses for their questions and reactions. After rounds, leaders share the feedback they heard through a dedicated listserv. That feedback then informs the next month’s newsletter to ensure an ongoing dialogue.

Components of HSHS1 St. John’s Hospital Connection Rounds

- Nurse Leaders
  - Create talking points and newsletter
  - Share feedback via dedicated listserv

- Frontline Nurses
  - Share information on upcoming standards
  - Give feedback on previous standards

Connection Rounds

- Three times per month
- Led by nurse managers and directors
- Take place around a snack cart
- Leaders respond to open-ended questions about standards

HSHS St. John’s Hospital Connection Rounds newsletter available at advisory.com/nec

Case in Brief: HSHS St. John’s Hospital

- 402-bed teaching hospital headquartered in Springfield, Illinois
- In 2015, introduced Connection Rounds as a way to share updates on standardization work and solicit feedback on previous and upcoming changes
- Nurse managers and directors conduct Connection Rounds on the same three days every month, covering day shift, night shift, and weekend shift
- Rounds are conducted around a snack cart to gather individuals and facilitate conversation
- Leaders equipped with talking points regarding upcoming protocol and policy changes, as well as updates on HSHS St. John’s five pillars of performance: service, quality, growth, people, finance; talking points are presented in a user-friendly newsletter format
- Following rounds, leaders send all questions from frontline nurses and follow-up items to an email listserv that contains all nursing leaders

Source: HSHS St. John’s Hospital, Springfield, IL; Nursing Executive Center interviews and analysis.
Since leveraging leader rounds for care variation reduction, leaders at St. John’s Hospital have observed an increase in culture of safety and employee engagement scores.

**Dramatically Improving Engagement**  
*Results at HSHS St. John’s Hospital*

<table>
<thead>
<tr>
<th>Culture of Safety Scores</th>
<th>Colleague Engagement Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Percentiles</strong></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>2017</td>
</tr>
<tr>
<td>10%</td>
<td>63%</td>
</tr>
<tr>
<td>2015</td>
<td>2017</td>
</tr>
<tr>
<td>27%</td>
<td>90%</td>
</tr>
</tbody>
</table>

Leaders at St. John’s Hospital believe the standardization of leader rounding has been critical to their success, because all units hear a consistent message and have an opportunity to provide feedback about care standards. This page provides three key components of an effective conversation when leveraging leader rounding for care variation reduction.

**Standardize Leader Rounds Across Units**

**Elements of Effective Connection Rounds**

**Talking Points to Introduce Changes**

- Introduce what the care standard is
- Identify how the new standard impacts frontline workflow
- Provide set of next steps

**Questions to Solicit Feedback**

- What questions can I answer for you?
- What challenges have prevented you from following the standard?
- Who has found a way to overcome this obstacle?

**Wrap-Up to Extend Conversation**

- Provide additional resources for more information
- Offer to continue accepting questions and feedback

Source: HSHS St. John’s Hospital, Springfield, IL; Nursing Executive Center interviews and analysis.
A second way to tap into an existing communication channel to solicit ongoing feedback and questions on care standards is to leverage shared governance.

St. John’s Hospital added a standing Spotlight Policy agenda item to their monthly house-wide shared governance meeting. The standing agenda item ensures that the group reviews standards regularly, as opposed to on an ad hoc basis. The house-wide committee uses the time to review nursing-specific care standards, as well as interdisciplinary care standards.

### Use Shared Governance to Review Care Standards

#### Spotlight Policy Agenda Item at HSHS St. John’s

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Call to Order</td>
<td>0800-0805</td>
</tr>
<tr>
<td>Reflection</td>
<td>0805-0930</td>
</tr>
<tr>
<td>Standing Agenda Items</td>
<td></td>
</tr>
<tr>
<td>1. People Services</td>
<td></td>
</tr>
<tr>
<td>2. Education</td>
<td></td>
</tr>
<tr>
<td>3. Infection Prevention</td>
<td></td>
</tr>
<tr>
<td>4. Patient Satisfaction</td>
<td></td>
</tr>
<tr>
<td>5. CNO Update</td>
<td></td>
</tr>
<tr>
<td>6. WOW Cart Drawers and Plan for EPIC</td>
<td>0930-1000</td>
</tr>
<tr>
<td>7. Break</td>
<td>1000-1010</td>
</tr>
<tr>
<td>9. Review of Code Policy</td>
<td></td>
</tr>
<tr>
<td>+DISCUSSION OF UNIT COUNCIL GUIDELINES</td>
<td>10:10-10:55</td>
</tr>
</tbody>
</table>

#### Key Components

- Nurses regularly **review** new standards
- Reviews emphasize **workflow improvement**
- Nurse executive and medical executive committees filter initiatives down, so shared governance committee reviews multidisciplinary standards

#### Case in Brief: HSHS St. John’s Hospital

- 402-bed teaching hospital headquartered in Springfield, Illinois
- Revamped shared governance structure in 2015, so that all unit-level councils report to a house-wide shared governance committee
- As part of revamp, replaced unstructured breakout sessions with a Spotlight Policy standing agenda item; each month, the shared governance committee shines a spotlight on nursing policies that are up for review
- Additionally, nurse executive and medical executive committees send multidisciplinary standards to the house-wide shared governance committee for review
Solicit Feedback from Nursing Councils

Three Worthwhile Conversations to Have with Participants

- **Review Emerging Standards**
  - What questions do you have about this standard?
  - Is there enough information to understand why the standard is important?
  - Are the necessary supplies easily accessible?

- **Revisit Existing Standards**
  - Is this standard hard or easy to follow today? Why?
  - Has anything changed to make this standard harder to follow?
  - What are your suggestions to improve this standard? How can we make it easier to follow?

- **Examine Cases and Drivers of Noncompliance**
  - Which standards are least commonly followed on your unit? Why?
  - What steps within those standards are most challenging to follow?
A third way to tap into an existing communication channel to solicit ongoing feedback and questions on care standards is to leverage your EHR.

Texas Health Resources leveraged their EHR by adding a help button on each system computer. The button is prominently featured so clinicians can find it quickly and easily. After clicking on the button, the computer opens a free-text email, where clinicians can type any comments or questions they have about a care standard. The email is sent directly to the system-level design team.

THR Builds an EHR Help Button for Feedback

Illustrative Example of Texas Health Resources’ Feedback Loop

Sample Clinician Feedback
“I don’t understand this care standard”
“When did this standard start?”
“Our facility does not have this test”

Case in Brief: Texas Health Resources

- 29-hospital health system with more than 5,500 affiliated physicians; headquartered in Dallas-Fort Worth, Texas
- In 2015, deployed the Reliable Care Blueprinting™ (RCB) initiative at all 18 acute care hospitals to reduce unwarranted variation through care redesign
- Recognizing the possibility that care redesign could increase frontline workflow burdens, the RCB team added help buttons on every computer to gather frontline feedback on care standards
- The help button opens a pre-addressed email allowing clinicians to provide their in-the-moment feedback on care standard workflow
- One RCB team reviews and responds to all clinician feedback and brings feedback requiring further attention to weekly meetings

Source: Texas Health Resources, Dallas-Fort Worth, TX; Nursing Executive Center interviews and analysis.
The previous pages highlighted three ways organizations have leveraged existing communication channels to solicit ongoing frontline feedback and questions on care standards. There are a variety of additional channels that organizations can tap into. This page provides other examples of communication channels to leverage for care variation reduction.

Use an Existing Communication Channel for CVR

Example Communication Channels

- Leader rounding
- Shared governance
- EHR
- Intranet site
- Staff meetings
- Newsletter
- Pulse surveys

Source: Texas Health Resources, Dallas-Fort Worth, TX; Nursing Executive Center interviews and analysis.
Component 2: Routinely review and respond to all feedback and questions

The second component of this tactic is to routinely review clinician feedback and respond.

Texas Health Resources has a regimented process for reviewing feedback submitted through the EHR help button. Once a week, the system design team meets to discuss each message and determine next steps.

There are three categories of feedback THR typically receives. The first category is questions about how to perform a standard. In response, the design team at THR provides additional information. The second category is requests to be exempt from a care standard. THR responds by either granting or denying the request. Nearly all requests are denied, but in each case THR provides additional education to help overcome implementation barriers. The third category is legitimate flaws with the care standard. In those cases, the design team at THR revises the care standard appropriately.

Regardless of the outcome, it is critical that either the design team or a clinical leader responds to each piece of frontline feedback. Four considerations to keep in mind when crafting a response are shown here.

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Three Outcomes of the Feedback Review Process

Texas Health Resources’ Frontline Feedback Loop

Provide Additional Education
- Users ask questions surrounding specific changes in workflow
- Provide education about new workflow

Address Concern, Approve or Deny Request
- Users request to be exempt from workflow change; nearly all requests are denied
- Provide additional education about why the workflow was established

Validate Concern, Iterate on Standard
- Users identify flaw in the workflow
- Design team works on logic for alert exclusions, adjusts order sets, etc.

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Four Questions to Consider When Responding to Frontline Feedback

- Did you respond in a timely manner
- Did you thank the clinician for his or her input?
- Did you provide a clear response?
- Did you offer support in follow-up or next steps?

Source: Texas Health Resources, Dallas-Fort Worth, TX; Nursing Executive Center interviews and analysis.
Tactic 11: Peer Coach Cohort

Tactic in Brief
Establish a cohort of frontline peer coaching experts. The goal is to develop coaches who can support their peers on any care standard and alleviate some pressure from nurse managers and clinical educators.

Rationale
Many organizations rely on their nurse managers and clinical educators to do most of the coaching on new care standards, or they recruit and train new peer coaches for every new care standard. Both approaches can be effective, but they are time consuming and difficult to scale across competing priorities. In contrast, developing peer coaches to be expert in coaching techniques—not individual standards—allows them to support multiple care standards at once.

Implementation Components
Component 1: Establish a cohort of expert peer coaches
Implement a cohort model, in which a dedicated group of peer coaches supports frontline nurses across a variety of units and care standards. Provide dedicated time for peer coaches to complete associated responsibilities.

Component 2: Clarify roles and responsibilities for all peer coaches
Identify coaching responsibilities that are relevant for any care standard and codify them into a formal coaching job description.

Component 3: Recruit peer coaches based on coaching capabilities
Identify the right frontline nurses by asking managers to select strong performers who have rapport among their teams. They should either already be serving as informal coaches or have demonstrated the potential to coach.

Component 4: Train coaches on universal coaching skills
Train coaches on quality improvement methodology and the basics of change management so they have foundational knowledge to apply to multiple standards.

Tactic Assessment
We recommend this tactic for organizations implementing a high volume of care standards at once. Developing a peer coach cohort that can support any standard can be more scalable than recruiting new peer coaches for each new standard that rolls out. Establishing a peer coach cohort is less resource-intensive than relying solely on clinical educators, but it may require some additional costs when reallocating a portion of coaches’ time away from direct bedside care.

Source: Nursing Executive Center interviews and analysis.
Component 1: Establish a cohort of expert peer coaches

The first component of this tactic is to establish a cohort of expert peer coaches. Legacy Health had a high volume of new and updated care standards that they needed to reinforce for frontline nurses. Rather than designating a coach for each care standard, leaders at Legacy established a cohort of coaches to support all care standards.

Details of the cohort are shown here. Legacy deploys one to ten peer coaches per facility, depending on facility size. For example, a 550-bed hospital has ten coaches, and a 100-bed hospital has three. On average, each peer coach works one dedicated coaching shift per pay period, during which time the coach focuses on two or three standards simultaneously.

Example Care Standards at Legacy Health

- Discharge and medication communication to improve HCAHPS
- Catheter protocols to prevent CAUTI and CLABSI
- Insulin administration to prevent hypoglycemia
- Pressure injury prevention

Legacy’s Cohort Model for Peer Coaching

- 1-10 coaches per facility, depending on size
- Coaches work dedicated coaching shifts
- Coach on 2-3 standards at a time, depending on priorities
- Rotate across units within their facility

Case in Brief: Legacy Health

- Eight-hospital health system headquartered in Portland, Oregon
- Began its peer coaching program in response to Oregon’s Hospital Transformation Performance Program (HTPP); HTPP was a state incentive program focused on how well hospitals reduce costs and improve patient safety across 11 metrics
- To become peer coaches, nurses submit applications to their managers, who then select candidates; ideal coaches have a BSN, two years of acute care experience, and are influential among their peers
- Legacy deployed between one and ten nurses as peer coaches in each of its six Oregon facilities, depending on facility size; all coaches are overseen by Quality Department
- Coaches work either a dedicated coaching shift or a dedicated bedside care shift; they never split a single shift between the two responsibilities
- Typical time commitment is one 12-hour shift per pay period, but this fluctuates based on need in each facility
- Legacy has earned $56 million in HTPP incentives, and one of Legacy’s facilities was the first hospital to achieve a “perfect score” in the program

1) Hospital Consumer Assessment of Healthcare Providers and Systems.
2) Catheter-associated urinary tract infection.
3) Central line-associated blood stream infection.
Component 2: Clarify roles and responsibilities for all peer coaches

The second component of this tactic is to formalize the peer coach role by clarifying specific responsibilities.

Nursing leaders at Legacy Health started by identifying coaching responsibilities that were relevant across all care standards. Example responsibilities include: attending change-of-shift huddles to remind oncoming clinicians of care standards, observing nurses practicing at the bedside, and providing peer feedback on care standard implementation.

Next, leaders at Legacy codified those responsibilities into the formal peer coach job description excerpted here.

Coaches Provide At-the-Bedside Guidance

Legacy Health’s Peer Coach Job Description

LEGACY HEALTH
Job Description
TITLE: Clinical Nurse Quality Coach

JOB SUMMARY:
The Clinical Nurse Quality Coach is a time-limited role that will help units implement process improvements aimed at improving clinical quality and patient experience. Monitors clinical processes and acts as unit resource as a peer coach by: (1) answering questions from peers regarding quality and patient safety initiatives, (2) directly observing patient care processes, identifies trends, patterns, and gives direct feedback to peers, (3) reviews clinical documentation, (4) makes recommendations for improving processes, (5) provides education related to quality measures including HTPP, (6) works with unit shared governance, various councils, committees, workgroups in support of identifying processes that can be improved. (7) Work in collaboration with clinical champions to ensure unit is updated on progress of quality workgroups and initiatives and quality data displays are up to date each month.

QUALIFICATIONS:
Education:
As required by licensure.
BSN or BS in related field preferred.

Experience:
Minimum of two years acute-care clinical experience preferred. Epic experience in the functional area (Critical Care, Medical, Surgical, ED, and Perioperative) preferred.

Licensure/Certification:
Current applicable state RN license required.

Example Responsibilities:

![Checkmark for Attend:]
- Shift change huddles
- Staff meetings
- Shared governance

![Checkmark for Observe:]
- Bedside practice
- Communication with patients

![Checkmark for Provide:]
- Education on standards
- Instructions on new tools
- Feedback to unit leaders

Legacy’s Peer Coach job description available at advisory.com/nec

Source: Legacy Health, Portland, OR; Nursing Executive Center interviews and analysis.
The third component of this tactic is to select peer coaches based on their coaching capabilities.

Legacy implemented a thoughtful process to select nurses with an aptitude for coaching. First, Legacy had an open call for applicants to create a pool of nurses who were interested in peer coaching. Next, managers vetted the applications. Managers looked for nurses with significant experience and education to draw upon. They also looked for skills that suggested an aptitude for coaching, such as influence and communication. Based on that criteria, managers made the final selection of peer coaches.

**Legacy Health’s Peer Coach Selection Process**

1. Open Call for Applications
2. Manager Vetting of Applications
3. Manager Selection of Peer Coaches

**Peer Coach Selection Criteria**

**Requisite Experience**
- BSN or BS prepared
- Two years working in acute care

**Idea Skill Profile**
- Demonstrated influence and communication skills
- Demonstrated potential to coach
- Excellent knowledge of workflows

Source: Legacy Health, Portland, OR; Nursing Executive Center interviews and analysis.
Component 4: Train coaches on universal coaching skills

The fourth component of this tactic is to train coaches on universal coaching skills, not just on specific standards.

Peer coaches at Legacy Health go through the three-part training shown here. Collectively, this training prepares coaches with tools and techniques that are applicable to all care standards.

Legacy Health’s Peer Coach Training

Science of Quality Improvement
- Health care’s Triple Aim¹
- Legacy’s care standards

Basics of Change Management
- Stages of workplace change

Nuts and Bolts of Coaching
- Role expectations
- Asking effective questions
- Coaching job aides

Peer Coaches Prepared to Support Multiple Standards

¹ From the Institute for Healthcare Improvement; includes improving patient experience, improving the health of populations, and reducing the per capita cost of health care.

Source: Legacy Health, Portland, OR; Nursing Executive Center interviews and analysis.
Tactic 12: CVR Primer for Preceptors

**Tactic in Brief**

Provide dedicated training and support to preceptors so they understand the organization’s care variation reduction strategy. The goal is to educate preceptors about the importance of care variation reduction and help them reinforce care standards among new nurses.

**Rationale**

Preceptors are critical first points of contact for new nurses. In addition to training new nurses, preceptors serve as important role models. Yet many preceptors either don’t follow care standards correctly themselves, or might not teach care standards correctly to new nurses. Both situations undermine the organizations’ efforts to standardize care—and can create greater variation in the long term.

**Implementation Components**

**Component 1: Give preceptors a primer on care variation reduction**

Customize the Nursing Executive Center’s Primer on Care Variation Reduction slides to have a conversation with preceptors about what care variation reduction is—and the important role they play.

**Component 2: Audit your opportunities to better leverage preceptors for care variation reduction**

Complete the Nursing Executive Center’s audit to identify opportunities to better leverage and support preceptors throughout your organization’s care variation reduction efforts.

**Tactic Assessment**

We recommend this tactic for all organizations, because preceptors have an outsized influence over how new nurses practice and the extent to which they follow care standards. The Nursing Executive Center’s customizable Primer on Care Variation Reduction provides a low-investment way to teach preceptors how they can support care variation reduction efforts. Organizations that wish to make additional investments in their preceptor program can complete the Preceptor Opportunity Audit embedded in this tactic.
Many organizations underleverage their preceptors in care variation reduction. Preceptors have outsized influence on how new nurses practice and can emphasize the importance of following care standards. However, that doesn’t always happen in practice. For example, one survey of student nurses from three academic institutions found that nearly a quarter of new nurses witnessed preceptors contradicting the known standard of care.

The following pages outline two components to ensure preceptors teach care standards correctly and consistently—and understand the important role they have in reducing unwarranted care variation.

Accounting for Preceptor Influence

Survey Reveals Variability in Preceptor Practice

Compromised Best Practices

Most Common Themes

1. Infection control breaches
2. Unsafe workarounds
3. Substandard medication administration practices

24%
Of surveyed new nurses\(^1\) described seeing preceptors contradict best practices

Study in Brief: Moral Distress and Associated Factors Among Baccalaureate Nursing Students: A Multi-Site Descriptive Study

- A cross-sectional survey of 267 student nurses from three accredited academic institutions
- Study had three aims: measure moral distress among nursing students, identify reasons that students do not address the stressor, and identify events causing students’ stress
- Results show that moral distress among student nurses is brought about by clinical educators not performing adequate care and the subordinate role felt by students
- The most common preceptor violations were infection control breaches, unsafe workarounds, and substandard medication administration practices
- In response to these results, the University of Portland Nursing School places emphasis on a preceptor-preceptee partnership, a relationship in which both parties feel comfortable communicating any potential issues they may have

Source: Krautscheid L, “Moral Distress and Associated Factors among Baccalaureate Nursing Students: A Multi-Site Descriptive Study,” Nursing Education Perspectives, April 2016; Nursing Executive Center interviews and analysis.

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\(^1\) n=267 nursing students surveyed.
Introduce Preceptors to Care Variation Reduction

Customizable Slides on Care Variation Reduction

Component 1: Give preceptors a primer on care variation reduction

The first component of this tactic is to give your preceptors a primer on care variation reduction. Preceptors who understand care variation reduction—and why it’s important—will be stronger champions of the organization’s efforts. An effective primer includes: an introduction to care variation, an overview of your organization’s goals, and a call to action that helps preceptors understand how they can personally contribute.

The Nursing Executive Center has created customizable slides that you can use to educate your preceptors on care variation reduction concepts.

Why It’s Helpful:

- Introduces and defines care variation reduction concepts
- Explains why reducing care variation is important
- Outlines the critical role that preceptors play
- Provides editable slides and scripting

Customizable slides available at advisory.com/nec

Source: Nursing Executive Center interviews and analysis.
Component 2: Audit your opportunities to better leverage preceptors for care variation reduction

The second component of this tactic is to identify opportunities to better leverage preceptors in your care variation reduction efforts.

A brief opportunity audit, mapped to the most relevant Nursing Executive Center resources, is shown here.

Enabling Preceptors to Support Care Variation Reduction

Preceptor Opportunity Audit

<table>
<thead>
<tr>
<th>Opportunity</th>
<th>Answer</th>
<th>Supporting Resource</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you introduced preceptors to your organization’s CVR strategy?</td>
<td>Yes</td>
<td>Primer on Care Variation Reduction customizable slides</td>
</tr>
<tr>
<td>2. Do you have a mechanism to keep preceptors up to date on new care standards?</td>
<td>Yes</td>
<td>Practice 2: Frontline Change Agent in <em>The High-Reliability Nursing Enterprise</em></td>
</tr>
<tr>
<td>3. Do you have preceptor resources in your implementation toolkit?</td>
<td>Yes</td>
<td>Toolkit for Building Implementation-Ready Care Standards</td>
</tr>
<tr>
<td>4. Have you trained preceptors to both give and receive practice critiques?</td>
<td>Yes</td>
<td>Tool 1: Guide to Delivering Effective Feedback in <em>First Year Nurse Retention Toolkit</em></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>Practice 7: Teaching Simulation Lab in <em>Bridging the Practice-Preparation Gap Volume II</em></td>
</tr>
<tr>
<td>5. Do you regularly ask preceptors what teaching supports they need?</td>
<td>Yes</td>
<td>Tool 2: Tailor Support to Preceptors’ Needs in <em>First Year Nurse Retention Toolkit</em></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

All resources are available at advisory.com/nec

Source: Nursing Executive Center interviews and analysis.
Want more on care variation reduction?

This report is a publication of the Nursing Executive Center, a division of Advisory Board. As a member of the Nursing Executive Center, you have access to a wide variety of material, including webconferences, research reports, implementation resources, our blog, and more. Check out some of our other work on reducing care variation.

**Implementation resource: Care Standard Implementation Toolkit**
Equip design teams with the tools they need to create implementation-ready care standards—every time.

**Executive briefing: The System Blueprint for Clinical Standardization**
Learn how top performers in clinical standardization have leveraged “systemness” to reduce unwarranted care variation

**Research report: The High-Reliability Clinical Enterprise**
Learn how to achieve high reliability across your health system despite the many complications posed by today’s care environment.

Visit us at: [advisory.com/nec](http://advisory.com/nec)
Email us at: [nec@advisory.com](mailto:nec@advisory.com)
The best practices are the ones that work for you.SM